Rethinking the Patients' Bill of Rights - pages 10-11

Health Care News

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2 NFIB, Fortis Team Up
4 The Case for Managed Care
6 Tennessee Tax Protest
10 Federal Takeover of Medicine?
12 Defined Contribution Primer
17 Revising Social Security Health Benefits

Tennessee Taxpayers Revolt

Protesters reject state income tax proposal, riot in Nashville

BY CONRAD F. MEIER

Tennessee lawmakers abandoned their efforts to pass a state income tax, aimed at funding the state's government-run health care system, after protesters chanting "No new taxes" broke windows in the capitol building in Nashville on Friday, July 13.

State police locked the statehouse after a crowd of nearly 200 jammed the area outside the Senate chambers. Some of the protesters banged on the doors and broke windows; others accosted lawmakers as they made their way through hallways with police escorts.

One demonstrator hurled a rock through the window of Gov. Don Sundquist's office while he was away from his desk. There were no immediate reports of arrests.

According to local news sources, Sundquist said after the protest, "I appreciate the right of all Americans to free speech and peaceful protest. I do not, however, approve of those who advocate violence, and I regret that occurred at the capitol."

As news of the tax proposal filtered out of the capitol and onto talk radio programs, protesters streamed to the statehouse demanding responsible government, not more taxes. Traffic at the capitol came to a standstill as other protesters honked car horns and waved signs reading "Tax Revolt!" and "No Income Tax."

TENNESSEE continued on page 6

A Tennessee taxpayer signs a No Income Tax banner used during mid-July protests at the capitol building in Nashville. Governor Don Sundquist, who proposed what would have been the state's first income tax, was named "Villain of the Month" by Americans for Tax Reform. *photo courtesy - WTN*

Pharmacy Groups File Suit Against U.S.

Complaint alleges Medicare Rx discount card program adopted unlawfully, won't aid seniors

BY CONRAD F. MEIER

The National Association of Chain Drug Stores (NACDS) and National Community Pharmacists Association (NCPA) have filed a complaint against Tommy Thompson, secretary of Health and Human Services, and Tom Scully, administrator of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), challenging the administration's recently announced Medicare prescription discount card initiative.

Filed July 17, 2001 in U.S. District Court in the District of Columbia, the suit claims HHS and CMS lack legislative authority to adopt the initiative. The suit also alleges violations of the Administrative Procedures Act and the Federal Advisory Committee Act and challenges the drug initiative as an unlawful delegation of regulatory power to a private consortium.

PHARMACY SUIT continued on page 15

Patients' Bill of Rights Opens Pandora's Box

BY CONRAD F. MEIER

In response to consumer dissatisfaction with managed care, the U.S. Senate on June 29 passed a version of the Patients' Bill of Rights (PBOR) intended to protect patients from alleged abuses in the managed care system and guaranteeing HMO participants broad new rights to sue their health plans.

But concern is growing in the managed care community, not only over the PBOR's potential negative impact on health care costs, but also its potential to pressure health care professionals into making tough choices that could result in negative patient outcomes.

According to economist Roger Feldman, editor of *American Health Care* (Independent Institute, 2000), "the Patients' Bill of Rights will likely make health-insurance premiums increase. Add to that the outlays (as high as 30 percent) that many HMOs spent on new equipment, drugs and facilities, and it becomes clear that health care costs won't be falling anytime soon."

Supporters of the PBOR say the medical and private-sector insurance communities are overstating the potential financial impact of such a bill. But HMOs in Georgia and Hawaii offer real-world examples of why managed care organizations are worried. Faced with added liability, HMOs insist they will be forced to raise premiums and shift that additional cost to employers. Ultimately, individual consumers insured by managed care plans—including senior and low-income citizens covered by government plans like Medicare and Medicaid—will pay the price.

Case Study #1: Georgia

Given all the media reports, the greatest concern seems to be that the patients' bill of rights will allow trial attorneys to turn HMOs into a cash cow. In an interview published by *bizjournals.com*,

BILL OF RIGHTS continued on page 9

INSIDE HEALTHCARENEWS

2 Bush Outlines Medicare Reform
3 The Pulse
8 State Legislative Update
11 PBOR: Unhealthy Remedy
13 The Galen Report
18 Health Care Reform on the Web

MY TURN

AN EDITORIAL BY CONRAD MEIER

Patients' Rights Debate Lacks Honesty *p.18*

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Health Care News

EDITORIAL OFFICES
The Heartland Institute
19 South LaSalle
Suite 903
Chicago, Illinois 60603
312/377-4000 voice • 312/377-5000 fax
email think@heartland.org

PRESIDENT
Joseph L. Bast

PUBLISHER
Nikki Saret

EDITOR
Diane Carol Bast

MANAGING EDITOR
Conrad F. Meier

ASSISTANT EDITORS
Greg Scandlen
Merrill Matthews

CONTRIBUTING EDITORS
Grace-Marie Arnett, Twila Brase
Bob Corkins, Dewey L. Crepeau,
Dr. Miguel A. Faria, Gerry Smedinghoff

CARTOONISTS
Mike Shelton
Chuck Asay

DESIGN AND PRODUCTION
Kevin Fitzgerald
Jennifer Beranek

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NFIB, Fortis Team Up for Affordable Insurance

BY CONRAD F. MEIER

The National Federation of Independent Business (NFIB) and Fortis Health have teamed up to make affordable health insurance plans available to 600,000 NFIB member businesses throughout the U.S.

The partnership will offer plans designed for small-business owners and their employees, as well as for individuals. NFIB members can choose small group and individual health insurance plans, as well as Medical Savings Accounts (MSAs), short-term medical insurance, and ancillary products like vision, dental, and prescription coverage.

NFIB members will work with specially appointed Fortis Health agents, who will perform the role of health care consultants with special training in the challenges small businesses face. Members can compare insurance premium rates among competitors, change providers, or purchase health insurance for the first time.

In a news release announcing the partnership, Ben Cutler, president and chief executive officer of Fortis Health, noted, "This union is a perfect match and a wonderful opportunity, because both partners possess a vast amount of experience meeting the needs of small businesses. It is through the combination of this expertise that we can provide members with the types of insurance products that are most beneficial to them."

The National Federation of Independent Business (NFIB) is the nation's largest small-business advocacy group. A nonprofit, nonpartisan organization founded in 1943, NFIB represents the consensus views of its 600,000 members located in every state.

According to *Best's Review*, Fortis Health is the country's leading provider of individual medical, small group, and short-term health insurance as well as Medical Savings Accounts and defined contribution products. The company provides health insurance coverage for over one million people nationwide and has more policies in force than any other insurer in the country. Fortis is headquartered in Milwaukee, Wisconsin and has operations offices in Minnesota, Idaho, Texas, Florida, and Ohio.

> **"NFIB members can choose small group and individual health insurance plans, as well as Medical Savings Accounts (MSAs), short-term medical insurance, and ancillary products like vision, dental, and prescription coverage."**

For more information…

WWW about Fortis Health's insurance products, MSAs, or ancillary products, call 800-4-FORTIS (800-436-7847), or visit the company's Web site at **http://www.fortishealth.com**.

For more information about NFIB, contact Carli Adams at 615/874-5252, email **Carli.Adams@nfib.org**, or visit the group's Web site at **http://www.nfib.com.**

Bush Outlines New Approach to Medicare Reform

BY GRACE-MARIE ARNETT

President George W. Bush took a first step toward a new conversation on Medicare reform, listing eight reform principles before an audience of about 200 people from the health sector on a beautiful summer day in the Rose Garden.

The eight principles are supportive of the premium support model of Medicare reform developed by Sens. Breaux and Frist and Chairman Bill Thomas, all three of whom had front-row seats in the Rose Garden. The President's talk was refreshing for what he didn't say: no demagoguery of the drug industry, no calls for price controls, no stories of people eating cat food to pay drug bills. He talked about the value of medical innovation and the need for Medicare to keep up.

Bush also backed a drug discount card program for seniors. But instead of focusing on the need for targeted subsidies to low-income seniors, as his original Immediate Helping Hand program would have done, he said Medicare would give a stamp of approval to private drug discount cards that meet certain criteria.

Not surprisingly, the second row of seats was occupied by John Rother and others from AARP, and Len Schaeffer of WellPoint, both of whom are already in line to offer discount cards. The White House is acting fast, requesting action on the proposal almost immediately.

Far from Ideal Reform

The drug discount card the President is proposing is a far cry from the bolder and more workable approach proposed by the Galen Institute and reviewed in detail in the July issue of *Health Care News*.

In that model, the drug card would be a vehicle to target subsidies to low-income seniors without drug coverage, and it ties the subsidy to participation in an insurance program for high-end coverage. The Galen plan would involve a number of potential competing players, including insurance companies, drug companies, financial intermediaries, disease management groups, retail drug chains, PBMs, state risk pools, etc.

The Senate Finance Committee was expected to mark-up a prescription drug bill the week of July 23, based upon adding a prescription drug benefit to existing Medicare, as put forth by Sen. Bob Graham (D-Florida). The approach is inconsistent with Bush's principles to incorporate a drug benefit into a reformed Medicare, and he will likely oppose it.

Once the House takes a vote on a patients' bill of rights, the focus of the health care debate will shift to prescription drugs.

Grace-Marie Arnett is president of The Galen Institute, http://www.galen.org.

For more information…

WWW To read the latest version of the Galen Prescription Drug Security Card plan, go to **http://www.galen.org/news/071001.html**.

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The Pulse

BY GREG SCANDLEN

Free-Market Health Care Reform in the News

Writing in *Slate*, Michael Kinsley argues on the one hand, the Patients' Bill of Rights validates liberal ascendancy. He points out "that no major Republican is out there saying, 'No. This violates my most basic free-market principles. Insurers should be free to offer any deal they want and consumers should be free to take it or leave it.'"

On the other hand, Kinsley writes, the PBOR is "liberalism ala mode," using lawyers rather than "the hobnailed boot of big government" to expand benefits to those already well-off.
Source: http://www.slate.com, June 21.

A Good Deal for Patients?

Cal Thomas says in the *Washington Times* that his physician "thinks the politicians have duped people into believing (the PBOR) is a good deal. He thinks government intrusion into medicine has created many of the problems government wants to repair." He concludes it is just another step towards HillaryCare.
Source: http://www.washtimes.com, June 27.

> **Private health plans have already reformed themselves to the point that the PBOR "seems anachronistic—like an idea whose time has gone."**

In the *Washington Post*, Amy Goldstein writes, "the private marketplace has reacted more rapidly than the government." She says private health plans have already reformed themselves to the point that, according to CIGNA's Allen Schaffer, the PBOR "seems anachronistic—like an idea whose time has gone." But she also quotes Wake Forest professor Mark Hall as saying the PBOR would create "a single clear uniform" standard for patient care.
Source: http://washingtonpost.com/wp-dyn/politics/specials/health/patientsrights/A4629-2001Jun30.html

Misguided and Dangerous?

NCPA research assistant Brad Lega has an op-ed in the *Tallahassee Democrat* that argues the whole notion of a patient "right" is misguided and dangerous, and that it will lead to state-controlled entitlement programs. He prefers "extending tax credits to individuals" and creating "a limited public safety net" for those who remain uninsured.
Source: http://web.tallahasseedemocrat.com/content/tallahassee/2001/07/07/opinion/0707.oped.lega.htm

Health Insurance: Who Pays?

Linda Chavez points out in the *Washington Times* that even when employers write the checks for health insurance, it is really workers who pay the bill. Yet they have little say over what kind of coverage they get. Unfortunately, most Americans think it is free, so they have an unlimited demand for services.
Source: http://w=www.washtimes.com.commentary/20010707-63939280.htm

"Medical Necessity" Questioned

On a more academic note, the Cato Institute has published a paper in its *Regulation* magazine on "The Futility of Medical Necessity." Author E. Haavi Morreim, a professor of bioethics at the University of Tennessee, maintains the whole concept of "medical necessity" is flawed. It implies a level of precision that is impossible in health care, and it can be defined in widely different ways depending on very subjective standards. Patients, therefore, do not know from moment to moment what is and is not covered under the terms of their contracts.

Morreim argues, "plans should jettison the notion of medical necessity and the vague promises of providing 'all the care you need.' Instead, plans should turn to guidelines-based contracting."
Source: http://cato.org/pubs/regulation/regv24n2/morreim.pdf

Lawsuit Approach Questioned

Even more rigorous is a new study by RAND that takes an in-depth look at the consequences of legal remedies to enforce "fair and efficient resolution of complaints and appeals."

RAND asks, "How Effective is the Legal System in Deterring Wrongful Practices?" and concludes: not very. Few of the people injured by medical negligence ever bring suit. The RAND report cites one study in Utah and Colorado that found only one-third of patients who were seriously injured ever filed a malpractice claim, and another by Harvard that found only 3 percent did. At the same time, RAND cites several studies that find "between half and two-thirds of claims are brought with no apparent indication of negligence."

Even when appropriate claims are filed, RAND says the less serious claims are over-compensated and the more serious ones are under-compensated. RAND also points out that these are the results with physicians, who make for sympathetic defendants. No such sympathy will deter juries when it is an insurance company being sued.
Source: http://www.rand.org/publications/IP/IP184

A wholly different perspective comes from the Acton Institute for the Study of Religion and Liberty. Gordon Johnson writes that since Christ said all men are free, "Congress should focus on revising our tax laws to grant patients the freedom to choose their own health care providers." If they have the right to choose, "they will have less need to exercise their right to sue."
Source: http://www.acton.org/research/comment/comment.html

Flexible Spending Accounts

Employee Benefit News ran a major article by Richard Quinn on allowing Flexible Spending Account (FSA) rollovers. He says, "all unused FSA amounts must be eligible for rollover from year to year and into retirement." He disagrees there would be a substantial revenue loss from the rollover, and says the "real danger" is allowing FSA funds to be diverted away from health care expenses.

Quinn has never been very friendly towards MSAs, but he says, "unless we get the consumer into the process, health care costs will continue to spiral out of control."
Source: http://www.benefitnews.com, June 15

NFIB Names Fortis its Provider

The National Federation of Independent Business (NFIB) has announced that Fortis will be the exclusive provider of health insurance for NFIB's HealthBenefits program. Fortis will provide MSA programs along with group and individual health insurance products, short-term medical, and ancillary coverages including vision, dental, and prescription coverage. (See story, page 1.)
Source: For more information, contact Carli Adams at 615/874-5252, email Carli.Adams@nfib.org, or go to http://www.nfib.org.

Employees Want Choice

Business Insurance reports on a Watson Wyatt survey that was presented to a recent AAHP meeting. The article says, "employees want more choices when selecting among health plans and many favor a 'defined contribution' payment system." The article said 80 percent of employees surveyed agreed with or were neutral to the idea of a fixed-dollar contribution for health plan purchases, but a similar percentage still want some employer involvement, including negotiating price and performance standards, and facilitating enrollment and premium payment.
Source: http://www.businessinsurance.com, June 25.

> **"Employees want more choices when selecting among health plans and many favor a 'defined contribution' payment system."**

Private Sector Insurance Attacked

In predictable fashion, The Commonwealth Fund continues to roll out its series on how awful private health insurance is. The news release for one study is headlined, "Employer Policies Create Barriers to Health Insurance Coverage." It lambastes employers for requiring eligibility waiting periods and for not providing full coverage to part-time employees.
Source: http://www.cmwf.org/media/releases/ha07082_release07102001.asp

The second misrepresentation tries to undercut the interest in individual tax credits by claiming the "individual health insurance market does not work well" for older adults. As always with Commonwealth studies, the spin in the press release is belied by the actual numbers in the study. For instance, the study reports that "nearly half (of the 1,523 people aged 50-64 surveyed) with individual coverage reported annual out-of-pocket premiums of at least $2,000. In contrast, only 16 percent of adults insured through their employer paid that much."

Need I state the obvious?

People who pay for their own insurance pay more than people whose employers pay for the insurance. Duh!

If "nearly half" pay at least $2,000/year, then over half pay less than $2,000. Now that should be the headline: "Over Half of Older Adults in the Individual Market Pay Less than $2,000/year for Coverage!"
Source: http://www.cmwf.org/media/releases/ha0708_release07102001.asp

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis located in Dallas, Texas. To sign up for his free weekly e-newsletter send an email to: HealthPolicyWeek-subscribe@yahoogroups.com. Scandlen can be contacted at GMScandlen@aol.com.

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The Case for Managed Care

Part two of a three-part series

BY STUART A. WESBURY JR., PH.D.

In Part One of this three-part series, we covered the macro history of managed care. Now we turn to a more in-depth discussion of the evolution of health care since World War II, which will give us a better understanding of why health care costs got out of control, and why fee-for-service medicine was viewed as the cost culprit.

Fee-for-Service the Norm

Fee-for-service health care was the norm after WWII. When you visited the doctor or got a blood test, you were expected to pay. Outpatient care was routinely excluded from health insurance policies, which generally covered only hospitalizations. If you wanted insurance to pay for your care, you had to be in a hospital bed. From the beginning, health insurance encouraged use of the hospital rather than a less expensive alternative, outpatient care.

Insurance paid the doctor when you were hospitalized, but generally did not pay for visits to the doctor's office. The emphasis on high-cost health care was established.

Over time, physician outpatient services began to be covered by insurance, but doctors continued to be paid each time they provided a service. This suited the public just fine. Plenty of service was utilized at little personal cost. All health care providers were happy to be paid each time they provided a service.

Expansion of health care services was dramatic, and patients were ready to take advantage of these services. A popular axiom was, "a bed built is a bed filled." The number of graduating physicians increased rapidly, as did the number of nurses, therapists, and other health care professionals.

For at least 25 years, this expansion of the supply of health care services had few detractors. The doctors did their thing and got paid. The hospitals did their thing and got paid, too. Patients still paid little out of their pocket. Everyone was happy.

Government Steps In

In 1965, Medicare was passed by Congress and signed into law. Now every American over the age of 65 had almost a blank check for health care. The health care system was unprepared for the explosion in demand for health care services.

As is true of many government programs, the up-front cost estimates for Medicare were far too low. Costs quickly outstripped appropriations.

Soon, the impact of Medicaid, the program for the poor, was being felt on both federal and state treasuries. The cost monster had appeared with a vengeance. A number of years ago, the governor of Colorado, Richard Lamm, called Medicaid the Pac-man of the state budget. Health care just chewed up the dollars.

This timeframe also saw the full impact of the federal health care research budget and the research investment of private companies in new health care technology, drugs, etc. Unfortunately, research seemed not to produce labor-saving innovations in health care, as was happening in most industries. Instead, innovations in health care produced new ways to treat diseases that were not being treated appropriately before. New equipment required new types of technical personnel to run the machines and provide patient treatments.

New health professional categories were created. More and more costs were added to the system. More care was being provided for more diseases. It looked like we would have a cure for everything.

Fee-for-Service Blamed

In the 1970s, the nation began to get serious about health care costs. A finger was pointed at fee-for-service: If you were a health care provider paid for every service you provided, the argument went, you would quite naturally provide more services.

It was noted at the time that Mississippi had one-half the number of surgeons per-capita that California had. Surgeons in Mississippi performed only one-half the number of surgeries per-capita as were performed in California. Yet it was easy to see that Mississippians were not dying on the streets from lack of surgery. Perhaps there was too much surgery being performed by too many surgeons in California?

The way the health care system was organized began to come under attack. Most physicians practiced alone or in small groups of two or three. They were paid fee-for-service and essentially had no practice restrictions. There was no incentive to save money or practice conservative medicine. Hospitals had no incentives to save either. They were paid for all their costs or paid what they charged. Physicians and hospitals had no incentive to work together to save money.

The incentives were all pushing for increased health care expenditures. That raised questions about why health care was organized this way. Was there not a better way?

More Harm than Good?

Compounding all this confusion, a contrarian movement appeared in the 1970s that decried the over-emphasis on costly health care service. Ivan Illich, in his book, *Medical Nemesis*, wrote, "Medicine unquestionably injures more than it cures … [it] stripped patients of the tools to take care of themselves."

Perhaps he was looking forward to research not yet done, such as the 1993 Harvard Study that concluded 1 million injuries per year were caused by the health care system itself, and 150,000 people died each year from health care system-induced problems and mistakes. The Harvard researchers concluded that too much health care was being delivered, and that the health care services themselves were causing major problems.

Ethical questions were being raised. How much care is too much? It became clear we could deliver much more care than we needed or could afford. As patients, we had become dependent on health services, turning to the health care system to handle our lifestyle-induced health problems, rather than taking responsibility for them ourselves.

> **"From the beginning, health insurance encouraged use of the hospital rather than a less expensive alternative, outpatient care."**

Enter Managed Care

If necessity is the mother of invention, then it was time to invent something new.

As noted in Part One of this series, we did at the time have examples of health care delivery systems that offered a chance to save money without compromising quality. These forerunners of HMOs were attractive alternatives. A so-called Jackson Hole group convened and with the help of Dr. Paul Ellwood, the concept of a Health Maintenance Organization was formally developed.

An HMO replaces fee-for-service health care. The sum of money available to an HMO is fixed. There is no incentive in an HMO to provide unneeded services. The HMO is committed, by contract, to provide necessary care for its patients and to keep patients healthy.

For a monthly fee, a person or family becomes an HMO member, and they are assigned to a primary care physician. This physician becomes responsible for the total care of each patient, including making the decision to refer a patient to a specialist.

Most HMOs have established procedures, sometimes called protocols, to be followed when patients develop serious problems. Frequently, these protocols emphasize a conservative approach to caring for the patient, rather than aggressive testing and treatment regimes. These protocols tend to reduce the use of high-tech/high-cost services.

The overall cost for patient care in an HMO is thus likely to be lower than the cost of care in insurance plans, usually called indemnity plans, that provide the patient with almost unlimited choices utilizing fee-for-service medicine.

Part Three in this series will identify why managed care provides hope for the future in the war against increasing health care costs.

Stuart A. Wesbury Jr., Ph.D. is professor emeritus in the School of Health Administration and Policy at Arizona State University's College of Business. With Joseph L. Bast and Richard C. Rue, Wesbury is the coauthor of Why We Spend Too Much On Health Care *(1992-1993). He can be reached by email at stu.wesbury@asu.edu.*

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Missouri Chamber Launches Innovative Approach to Small Group Insurance

BY CONRAD F. MEIER

Leave it to the Show Me State to lead the way with ground-breaking health insurance solutions using market-based principles. The Missouri Chamber of Commerce has announced it will offer a modified version of self-insurance to small group employers stung by rising premium costs.

According to a recent Missouri Chamber survey, one of three small employers in the state can't afford to offer health benefits to employees. The chamber aims to correct that situation with Missouri ChamberCare: a cost-management program allowing employers to stabilize insurance costs by combining self-insurance and traditional private insurance contracts into one customized package. The "Care" in the program name stands for Customized Approach for Responsive Employers.

The plan works very much like the Employee Retirement Income Security Act (ERISA) of 1974, which makes it possible for major corporations to self-insure for health care. Like ERISA, ChamberCare will allow employers to cover the cost of claims up to a certain amount, called a stop-loss. Once the contractual stop-loss is reached, a high-deductible insurance policy pays the amount over the stop-loss. The stop-loss is a very customizable feature tailored to fit the financial capabilities and individual needs of the small group employer.

For more information…

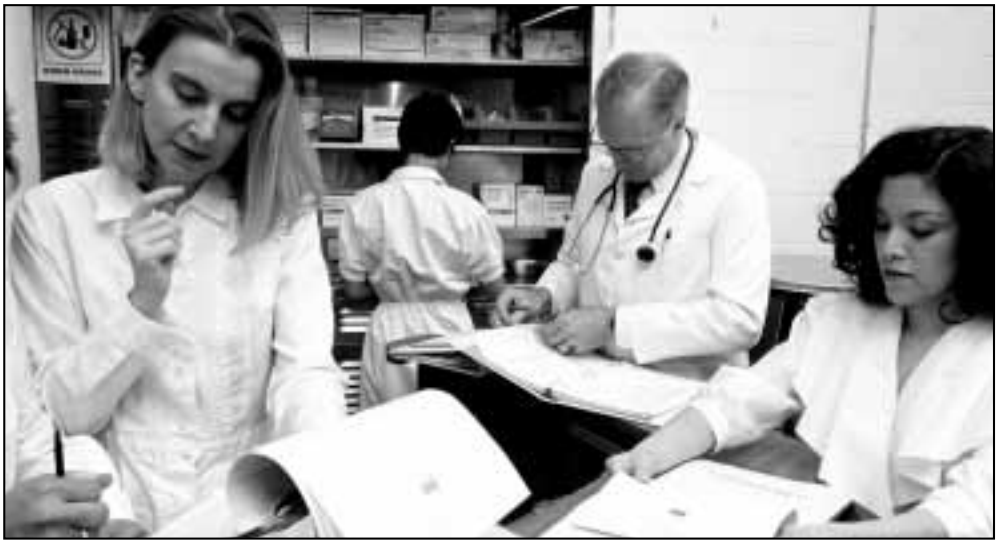
WWW about Missouri ChamberCare, contact chamber President Dan Mehan at dmehan@mochamber.org, or visit the chamber's Web site at **http://mochamber.org**.

In a press interview, Missouri Chamber of Commerce President Dan Mehan explained the cost advantages of the plan. "Employers find that if you pay as you go, instead of paying an insurance company in advance, you can cut costs substantially."

The *St. Louis Post-Dispatch* reported a dramatic example of how the plan would work. ASI Signage Systems of St. Louis, which adopted a version of ChamberCare on its own before the idea was presented to the Chamber, saved $17,000 over three years of small group insurance premiums, said company spokesperson Mark Scott. The company has also avoided having to increase insurance premiums for its 25 employees. The firm has a $3,000 stop-loss on each employee, after which an insurance company picks up the rest, less deductibles.

The ChamberCare plan was developed by Howard Danzig and Kenneth Nicklas, two insurance brokers who are also Chamber members. They marketed the plan to individual clients, including ASI Signage, before selling the Chamber on the idea. The Chamber-adopted plan will be administered by their brokerage firms, Danzig Insurance Company of St. Louis and Nicklas Financial Companies of Jefferson City, Missouri.

No other state chamber offers such an approach to market-based, small group health insurance. The Missouri Chamber of Commerce conducted statewide seminars in June to explain the new ChamberCare program.



Recently Released . . .

A review of key health care publications recently released, compiled by The Galen Institute.

Pharmaceutical Price Controls and Patient Welfare

Author: John E. Calfee, Ph.D.
Source: *Annals of Internal Medicine* Volume 134, 6/5/01

John Calfee of the American Enterprise Institute examines the negative effects of price controls on pharmaceutical R&D and patient welfare. He describes the important role market-based pricing structures play in pharmaceutical research and development and explains how government price controls would "substantially reduce incentives to pursue innovative research, as is evident in advanced economies in which price controls are now in force."

FOR MORE INFORMATION . . . The full text of John Calfee's article, "Pharmaceutical Price Controls and Patient Welfare," is available on the Internet at **http://www.aei.org/ra/racalf010605.pdf**.

Jeffordsonian Health Care

Author: Robert Goldberg
Source: *National Review* Online 6/4/01

The real impact of Senator Jim Jeffords leaving the Republican Party may be on health care, says Robert Goldberg of the National Center for Policy Analysis. With Jeffords' departure from the Republican Party, the powerful Kennedy-Clinton health care base will have the upper hand; it can be expected to push the Patients' Bill of Rights, expansion of Medicaid, and a prescription drug benefit with price controls and limits on patents.

FOR MORE INFORMATION . . . The full text of Robert Goldberg's guest commentary for *National Review* Online can be found on the Internet at **http://www.nationalreview.com/comment/comment-rgoldbergprint060401.html**.

Right and Wrong Ways to Address the Needs of the Uninsured

Author: James Frogue
Source: The Heritage Foundation

The recently passed federal budget contains $28 billion to help reduced the number of uninsured Americans. In his final Heritage Foundation paper before joining Rep. Kay Granger's (R-Texas) staff as legislative assistant, Jim Frogue outlines the right and wrong ways to spend that money.

FOR MORE INFORMATION . . . The full text of Frogue's June 4 Executive Memorandum is available on The Heritage Foundation's Web site at **http://www.heritage.org/library/execmemo/em750.html**.

Why Adopting the "Common Ground" Health Care Proposal Would Be a Costly Mistake

Author: Robert E. Moffit, Ph.D.
Source: The Heritage Foundation

The "Common Ground proposal" developed by the Health Insurance Association of America (HIAA) and Families USA contains unsound health policy, says Robert Moffit of The Heritage Foundation.

The proposal is flawed for a number of reasons, according to Moffit. For example, its requirements would be extremely difficult for businesses to implement, requiring them to gather "an unreasonable amount of personal information on household income to verify legibility."

FOR MORE INFORMATION . . . Robert Moffit's analysis of the Common Ground proposal is available on the Internet at The Heritage Foundation's Web site: **http://www.heritage.org/library/backgrounder/bg1445es.html**

A Better Patients' Bill of Rights

Author: John Hoff
Source: National Center for Policy Analysis

The proposed Patients' Bill of Rights would greatly increase litigation, increase the cost of health insurance, and decrease the number of Americans with health insurance, according to health care attorney John Hoff.

In a paper for the National Center for Policy Analysis, Hoff contends litigation causes "more money [to be] spent in the friction of the process than in compensating injured victims"; it is "time-consuming and delays recovery for injured plaintiffs," he says.

FOR MORE INFORMATION . . . The full text of John Hoff's *Brief Analysis*, issued on April 19, is available on the NCPA Web site at **http://www.ncpa.org/ba/ba355/ba355.html.**

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Tennessee Tax Protest:
A Report from the Front Lines

Tennessee tax protesters attracted continuing press coverage—not only in the state, but across the country—for their opposition to proposals for a new state income tax. Two of Nashville's competing talk radio stations, WLAC and WTN, joined forces and served as the catalyst for the protests. *photo courtesy - WTN*

The Volunteer State lived up to its nickname the week of July 9, when taxpayers "tired of politicians picking their pockets at every turn" turned out in droves to protest a legislative proposal to adopt an income tax. Policy analyst Patrick S. Poole was in the thick of things and reports here from the front lines.

Police cars blockaded entrances to the Tennessee state capitol building, and troopers patrolled legislative hallways this week as the state legislature found itself under siege by thousands of angry taxpayers upset at a plan to implement a state income tax.

Tennessee is currently one of only nine states without a state income tax. Opponents of the measure, which would assess a 5 percent tax on any income above $100,000, are skeptical that legislators would maintain that high an exemption threshold for very long.

Tax Protest Déja Vü

As protestors began to gather outside the legislative chambers Monday evening, several legislators were taken away by ambulance and hospitalized for blood pressure and heart problems as tensions rose and tempers flared.

By Tuesday morning, tax protestors were brandishing signs reading, "Let's send them all to the ER!"

On Friday evening, the state income tax proposal emerged from a legislative conference committee considering the state budget . . . after local news shows had already aired.

Legislators supporting the income tax proposal had hoped a vote

TENNESSEE continued from page 1

Talk Radio Gets Legislators' Ear

Steve Gill, a Nashville radio talk show host who helped organize the protests, told *The Nashville Tennessean*, "The people are passionate when they say no income tax." He had made the tax bill a central part of his programming, doing live broadcasts of his show from the capitol and staging demonstrations against the tax bill as it moved through the legislature. A big cheer went up as word spread the senate had passed the "no new revenue budget."

The senate, ending the longest legislative session in Tennessee's history, voted 20-9 in favor of a budget that uses $560 million of the state's tobacco settlement money to balance the books. The house later approved the spending plan 72-25. Sundquist has said he will veto the bill. Senate and house members had earlier met behind closed doors, with discussions apparently centering on a proposed flat-rate income tax ranging from 2.75 percent to 3.5 percent.

Tennessee—one of nine states without a broad-based income tax—has one of the highest sales tax rates in the country, at 6 percent. Local governments in the state add as much as 2.75 percent.

Income tax proponents in the legislature have tried unsuccessfully for the past three years to pass an income tax, including in special sessions ordered by Sundquist.

TennCare to Blame

The drive to fund TennCare led to the legislature's proposal for a first-ever state income tax on Tennessee residents . . . a plan that clearly did not go over well with the state's taxpayers.

TENNESSEE continued on next page

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would be taken on Saturday morning to avoid giving anti-tax groups time to mount a repeat of the tax revolt that occurred last November, when an earlier income tax measure died as taxpayers besieged legislative offices with tens of thousands of calls and emails every hour.

Talk Radio Fans Flames of Protest

But the hopes of income tax supporters were dashed when two of Nashville's competing talk radio stations, WLAC and WTN, joined forces and served as the catalyst for opposition to the legislative proposal.

Speaking to WorldNetDaily and barely audible above the virtually non-stop horn honking, WLAC's morning show host Steve Gill gestured to the standstill traffic encircling the state capitol and said, "Do you hear that? That's the sound of freedom."

Phil Valentine, Gill's afternoon show counterpart, chided legislators on-air for conducting most of the legislative discussion regarding the state budget behind closed doors.

"If this is such good public policy, why are they afraid to do it in public?" Valentine asked.

While it appeared Monday that income tax supporters had enough votes to push the measure through both houses, support crumbled as the tax protests grew.

"These legislators have received a rude awakening in the past few days," said Darryl Ankarlo, morning drive-time host for WTN. "They're realizing that taxpayers are tired of politicians picking their pockets at every turn."

Ankarlo and his WTN colleague, Dave Ramsey, began broadcasting their respective programs from a remote radio site located at the entrance of the legislative plaza, where they could wave to supporters driving by. They would regularly announce on-air the position of state legislators on the income tax proposal and provide telephone and email information for constituents to contact their representatives.

Governor Reneges on No-Tax Promise

The effort to pass a state income tax was led by Republican Gov. Don Sundquist, who won two gubernatorial races handily in 1994 and 1998 after promising to prevent an income tax from ever being passed. But less than three months after his 1998 re-election, Sundquist found that a runaway budget, driven by the largest state Medicaid program in the country, threatened to bankrupt the state.

> **"Legislators supporting the income tax proposal had hoped a vote would be taken on Saturday morning to avoid giving anti-tax groups time to mount a repeat of the tax revolt that occurred last November . . ."**

TennCare, the state's Medicaid program, now covers one out of every four citizens in the state and consumes one-quarter of the state's annual budget.

Rejecting calls to cut his proposed $18.1 billion budget, Sundquist threatened to withhold public works projects in legislators' districts if they failed to go along with his plan. Sundquist was backed by a coalition of liberal special-interest groups, state contractors, road builders, and state employee unions, who are pushing for the income tax to finance a 6 percent pay raise for the coming fiscal year.

One group, Tennesseans for Fair Taxation, praised the current tax proposal as the first step toward imposing a state income tax on the whole population, not just those earning more than $100,000.

"We will continue to push forward until we achieve comprehensive tax reform," said Nan Lloyd, a Tennesseans for Fair Taxation spokesperson. The organization has even posted an online tax calculator to tell families how much more they would end up paying under various state income-tax schemes.

One national taxpayer group has jumped into the Tennessee tax fight. Chad Cowan, director of communications for the Washington, DC-based Americans for Tax Reform, told WorldNetDaily that Tennessee legislators who vowed at election time to oppose the state income tax need to keep their promises.

"The people of Tennessee have spoken, and they have said loudly and clearly that they do not want a state income tax. The governor and legislature would be wise to listen to them," Cowan said.

"Villain of the Month"

Americans for Tax Reform named Sundquist "Taxpayer Villain of the Month" last November in response to his recommended state income tax plan and corresponding $400 million state spending increase. Sundquist's income tax effort was also panned recently by Steve Moore, a columnist for *National Review*, who labeled Sundquist "easily the worst governor in America."

The income tax proposal appeared dead, at least for another legislative session, after the tax measure's chief supporter announced he was throwing in the towel. Both houses subsequently referred the budget back to the conference committee responsible for crafting a compromise. Committee members were given explicit instructions to return with a bill that would meet legislative (and voter) approval.

Sundquist has threatened to veto any budget that does not include an income tax, but only a simple majority vote in both houses is needed to override the governor's veto. Most of the members in both the house and senate face re-election in November.

As word of the income tax's demise spread among the crowd gathered at the state capitol Tuesday night, car horns continued to blare and traffic remained at a standstill. One protestor, who said he had taken the day off work and had driven three hours to come to Nashville, spoke to WorldNetDaily as the crowd thinned and the sun began to set over the Nashville skyline.

"This is a great victory for all Tennesseans," he said. "The people spoke, and we forced our elected representatives to listen. Could anything be more American?"

Patrick S. Poole is a researcher and policy analyst with the Tennessee Public Policy Institute.

Tennessee lawmakers have been wrestling with TennCare, the failed state-run Medicaid health care plan, ever since President Clinton's national health care plan failed to pass Congress in 1994. TennCare acts as a single-payer health care system by virtue of numerous Medicaid waivers authorized by the Clinton administration.

Notes Patrick S. Poole of the Tennessee Public Policy Institute, "TennCare covers one out of every four citizens in the state and consumes one-quarter of the state's annual budget."

TennCare is the largest state Medicaid program in the country. While universal coverage and single-payer proposals have gained some attention in states across the country, no other state has embarked on such a grandiose effort down those paths. Incorporating universal coverage and single-payer goals into the state's Medicaid system has created a program difficult to maneuver, finance, and modify.

Prior to the Tax Revolt

On May 7, 2000, the Tennessee Public Policy Institute released a study of TennCare and recommendations for revising the state's health care system.

"On January 1, 1994, Tennessee embarked on an ambitious course to fundamentally change the state's Medicaid system," wrote policy analyst Patrick S. Poole. "The stated intent of the new program—TennCare—was to implement a managed care system to control the runaway growth of Medicaid expenditures seen during the close of the 1980s and the beginning of the 1990s under the fee-for-service payment system. The anticipated managed care savings would then be used to expand coverage to the uninsurable and the non-poor uninsured."

Poole continues, "To accomplish this feat, then-Governor Ned McWherter requested a Section 1115 waiver from the federal Health Care Financing Administration (HCFA) to mandate managed care for all TennCare enrollees and to allow coverage for those not eligible under Medicaid. After receiving HCFA approval, the state contracted with 12 managed care organizations (MCOs) to provide health care services to the entire TennCare population under a capitated rate payment system."

> **"Tennessee lawmakers abandoned their efforts to pass a state income tax . . . after protesters chanting 'No new taxes' broke windows in the capitol building in Nashville."**

The savings associated with TennCare's managed care approach have been achieved not through better utilization of health care services, but rather by deliberately under-estimating the capitated rates paid to managed care organizations. The MCOs shifted their losses to health care providers, which in turn passed on those losses to the insurers remaining in the private health insurance market. The net effect has been a decline in the overall quality of health care for all Tennesseans and increased premiums.

Restructuring Underway

In February 2001, Gov. Sundquist announced a restructuring of TennCare that divides the state market into three regions. Blue Cross Blue Shield of Tennessee, the largest TennCare MCO, agreed to withdraw from the West Tennessee TennCare market in order to improve opportunities for other regional health plans.

For more information…

WWW A summary of Patrick S. Poole's study can be found on The Heartland Institute's Web site at **http://www.heartland.org/ia/julaug00/excerpt.htm**.

At its peak, Blue Cross insured 645,000 lives in the state; under the restructuring, no MCO will cover more than 300,000 lives.

Last December, Blue Cross Blue Shield had notified the state of its intent to leave the program entirely unless it could negotiate better terms. It sought authority to administer TennCare statewide while shifting the financial risk to the state. Under the restructuring, Blue Cross has agreed to remain with the TennCare program as a full-risk MCO.

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State Legislative Update

A monthly review of state legislative activity

COMPILED AND EDITED BY CONRAD F. MEIER

FLORIDA

This year's legislative session was a mixed blessing for the state's residents.

Every one of the proposals for expensive, unfunded health insurance-related mandates failed to pass, so we can expect a stabilization of health insurance premiums and the possibility of more health insurance competition moving into the state.

Unfortunately, a proposal to re-open the state's long-shuttered high-risk health insurance pool failed.

ILLINOIS

Governor George H. Ryan signed into law two bills that provide Illinois women with help in their battles against breast and cervical cancers. House Bill 25 expands Medicaid coverage for women with breast and cervical cancer, and Senate Bill 866 requires coverage for breast reconstruction after a mastectomy.

"We want to make sure that low-income women are able to get treatment for the battle against breast and cervical cancer," Ryan said in a July news release. "We also want to make sure that once they are treated they are given every opportunity to get on with as normal a lifestyle as possible. Lieutenant Governor Corinne Wood pushed hard for these bills and deserves to be commended."

MICHIGAN

The Gramm-Leach-Bliley privacy bill was sent to the governor for his signature. The legislation closely follows model legislation from the National Association of Insurance Commissioners (NAIC), but it does not cover health insurance or medical care-related information.

Another bill waiting for signature is H.B. 4113, which creates a long-term care insurance premium deduction equal to 100 percent of the premium.

MISSOURI

The 91st General Assembly is adjourned, but a special legislative session will be called in September to address the issue of a new prescription drug program. The very tight state budget recently signed by Governor Bob Holden contains $63 million in tobacco litigation money earmarked for funding a new prescription program for seniors.

The governor also signed legislation raising the allowable income level for disabled Medicaid beneficiaries. Under the new law, Missourians can earn up to 2-1/2 times the federal poverty level and still qualify for taxpayer assistance. The new law allows income and asset limits to be calculated without regard to a spouse's income and assets. A disabled person earning up to $100,000 a year could qualify for Medicaid in Missouri.

NEBRASKA

The long-term care insurance tax incentive (L.B. 332) was not enacted this session, and neither was a measure to require prompt payment of health insurance claims, also known as "clean claims" legislation.

In the "if it ain't broke, don't fix it" department, L.R. 91 was approved and clears the way for a study to determine whether or not "clean claims" legislation is even needed.

NEW HAMPSHIRE

The individual health insurance bill deregulating the free market passed and goes to Governor Jeanne Shaheen for signature. This bill eliminates guaranteed issue in the private individual market and creates a high-risk insurance pool for residents with uninsurable medical conditions. Two thumbs up for the New Hampshire legislature!

NORTH CAROLINA

Numerous health care-related bills survived the "crossover" deadline, meaning they passed either in the House or the Senate and will be back to haunt legislators in the 2001-2002 session. Among them: H109, for the reimbursement of marriage/family therapists; H1232, for prescription drug assistance to seniors; and, we love this one, H1048, a moratorium on health insurance mandates.

On the Senate side, legislators passed S199, a managed care patients' bill of rights, and S714, amending certificate-of-need laws.

State legislators may propose cuts in the health benefits package offered to state employees and increase premiums in an effort to bridge an estimated $730 million shortfall in funding. It's a classic economics principle at work: When people think they are getting something for "free" or "cheap" they use more of it. In time, the needs become infinite, while someone else's money becomes finite.

And, speaking of other people's money, the governor's office has announced a plan to use part of the tobacco litigation settlement to pay for prescription drugs for the elderly.

OKLAHOMA

H.B. 131 was signed into law and provides enabling legislation to put the state in compliance with the Gramm-Leach-Bliley Act requirements. The bill also prohibits using group-size as a defining characteristic when dealing with such HIPAA compliance requirements as guaranteed issue or guaranteed renewability. This section of the law may be challenged in the courts, as HIPAA is quite clear and uncompromising on its definition of group-size.

OREGON

The state health plan was expanded to include Oregonians with incomes up to 185 percent of the federal poverty level while creating two tiers of benefits. The most vulnerable will receive the full benefits of the current plan. Single, healthy adults will get trimmed benefits and will pay premiums and co-payments. The plan is contingent on the new Center for Medicare and Medicaid Services (the old HCFA) granting the state a waiver of regulations on the use of federal health care money.

Lawmakers created a state subsidy for low-income seniors to obtain prescription drugs if they do not have prescription insurance coverage. They also approved a modified plan giving doctors authority to choose a lower-price drug for their patients if that drug is equivalent to a costlier name-brand drug.

TENNESSEE

The state-run health care plan, TennCare, is a pickpocket in search of deep pockets. A proposal to set a uniform sales tax rate of 8.5 percent, which would increase the tax on big-ticket items, was defeated by the state Senate as House members began considering a new income tax plan.

Meanwhile, Sen. Jim Kyle (D-Memphis) said a continuation budget approved June 29 could end up as the legislature's permanent answer to the budget problem because senators remain gridlocked.

The continuation budget keeps the troubled state health care plan, TennCare, barely intact and minimally funded for only necessary health and public safety programs but little else in improvements. Nose counts among the Senate's 33 members show no plan—neither an increase in the state sales tax nor creation of a state income tax—has the 17 votes it takes to pass.

In an effort to save TennCare, legislators may impose "pay or play" mandates on the state's business community, forcing them either to offer health insurance to their employees or pay TennCare to help cover the cost of insuring them.

State Rep. Gene Caldwell (D), chair of the state Joint TennCare Oversight Committee, told the *Chattanooga Times and Free Press*, "We have anecdotal evidence that a lot of small companies have dropped insurance so their employees can get on TennCare. We don't think that's right." He added, "The pay or play plan is the way the state might push business into participating."

Dave Goetz, president of the Tennessee Association of Business, responded, "Businesses are not (failing to offer) health care because they're bad people. They're not offering health care because they can't afford it. The idea that somehow all you have to do is pass a law and you will force companies to do something is really nonsensical. What you will force them to do is leave Tennessee."

State Sen. David Fowler (R) warned the proposal could "stifle entrepreneurship" and introduce "bankrupting costs."

Sources: The Council for Affordable Health Insurance (CAHI) and its member companies provided information for this State Legislative Update. Contact CAHI at mail@cahi.org, Additional material was provided by the National Association of Health Underwriters (NAHU), ***http://nahu.org/government****, http://bizjournals.com, and http://stateline.org.*

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U.S. Senator Byron Dorgan (D-North Dakota) studies a few notes as he awaits his turn at the microphone to fill in for no-show U.S. Senator Ted Kennedy. Dorgan addressed a July 11 news conference on the patients' bill of rights, called to counter President George W. Bush's version of the plan. *photo/Paul Richards-AFP.*

BILL OF RIGHTS continued from page 1

Kirk McGhee, director of the Georgia Association of Health Plans, said, "One 'runaway' trial verdict, resulting in a multimillion-dollar settlement, could be devastating."

Devastating because the health care system does not operate in a vacuum. Years of unfunded mandates big and small have forced HMOs to struggle in an effort to stay solvent; the PBOR would represent yet another such mandate.

> **"Faced with added liability, HMOs insist they will be forced to raise premiums and shift that additional cost to employers. Ultimately, individual consumers insured by managed care plans . . . will pay the price."**

Aetna Inc., the nation's largest health insurer, reported losses for the first quarter of 2001 and told shareholders costs had unexpectedly outpaced premium revenue. Cigna Corp. has said its profits will be lower than expected for the rest of the year. In Georgia, first-quarter profits dipped sharply for a handful of HMOs around the state, including United Health Care, Athens Area Health Plan, and Humana.

Health insurers face a major problem, as described to *bizjournal.com* by Brent Layton of Atlanta consulting firm Layton & Associates: "For one thing, they have found that they can't push down any further what hospitals and doctors charge. They've reached a negotiation bottom, costs are rising, and now the patients' bill of rights is looming."

Case Study #2: Hawaii

Local health care officials and businesses are especially concerned by one provision in the Senate version of the PBOR: the possibility that employers could be held liable for medical malpractice and wrongful death suits under the umbrella of health plan liability.

Although the Senate did away with the provision, the topic could be revived as Congress negotiates a compromise plan everyone can agree on. This provision has all the makings of a political poker chip.

Bette Tatum, state director of the National Federation of Independent Business, explained in an NFIB news release, "The absence of iron-clad protection from liability for an HMO's mistakes is a loaded gun pointed to the head of any small-business owner who provides health insurance for his or her employees—and in Hawaii (because of the play-or-pay mandate), that's everyone."

The federal legislation would supersede Hawaii's 1998 patients' rights law, which establishes a process for appealing to a three-member panel directed by the state insurance commissioner. The federal Employee Retirement Income Security Act (ERISA) already allows lawsuits against health plans, and many fear the PBOR would increase the number of lawsuits and size of damages awarded.

Although a provision in the Senate version of the bill currently says employers cannot be sued if they do not directly participate in the decision concerning health care coverage, how that provision is interpreted will have important implications for business. Simply choosing Plan A over Plan B could be construed as being "directly involved" in the health care decision process.

In an analysis of the PBOR's potential impact on the Aloha State, the Hawaii Medical Service Association cites Congressional Budget Office estimates that the PBOR would increase health care costs by 4 percent. For Hawaii, HMSA calculates, a small business with 20 employees could expect an increase of $2,000 per year in health care costs. HMSA also cites Employment Policy Foundation research, concluding lawsuits could increase costs to employers and health plans by between $7.9 and $16.3 billion.

For more information…

WWW A summary of Roger Feldstein's book, *American Health Care*, is available on the Independent Institute's Web site at **http://www.independent.org/tii/content/briefs/BriefAmHealthCare.html**.

Double-Edged Sword

In response to early complaints that managed care too tightly restricted consumer choice, HMOs over the years have expanded their patients' options . . . but the increased choice has not come cheap. By giving plan members access to a larger number of health care providers, HMOs limited their ability to negotiate rates, because they cannot guarantee providers cost-effective patient volumes.

Increasing HMOs' vulnerability to legal action will accelerate the rising cost trend. In the worst-case scenario, some employers will throw up their hands—either in frustration over the rising costs, or in fear of subjecting themselves to legal liability—and drop heath benefits altogether.

> **"The absence of iron-clad protection from liability for an HMO's mistakes is a loaded gun pointed to the head of any small-business owner who provides health insurance for his or her employees—and in Hawaii (because of the play-or-pay mandate), that's everyone."**
>
> **Bette Tatum, Hawaii state director**
> **National Federation of Independent Business**

Passage of PBOR could thus stimulate activity in health plan options like defined contribution plans, where employees are given tax-favored money each year to purchase their own health insurance. The American Medical Association and many individual health policy analysts have said defined contribution plans could be a good thing for consumers, giving them greater freedom to select a health plan tailor-made for their own circumstances, as well as all the consumer rights available under contract law.

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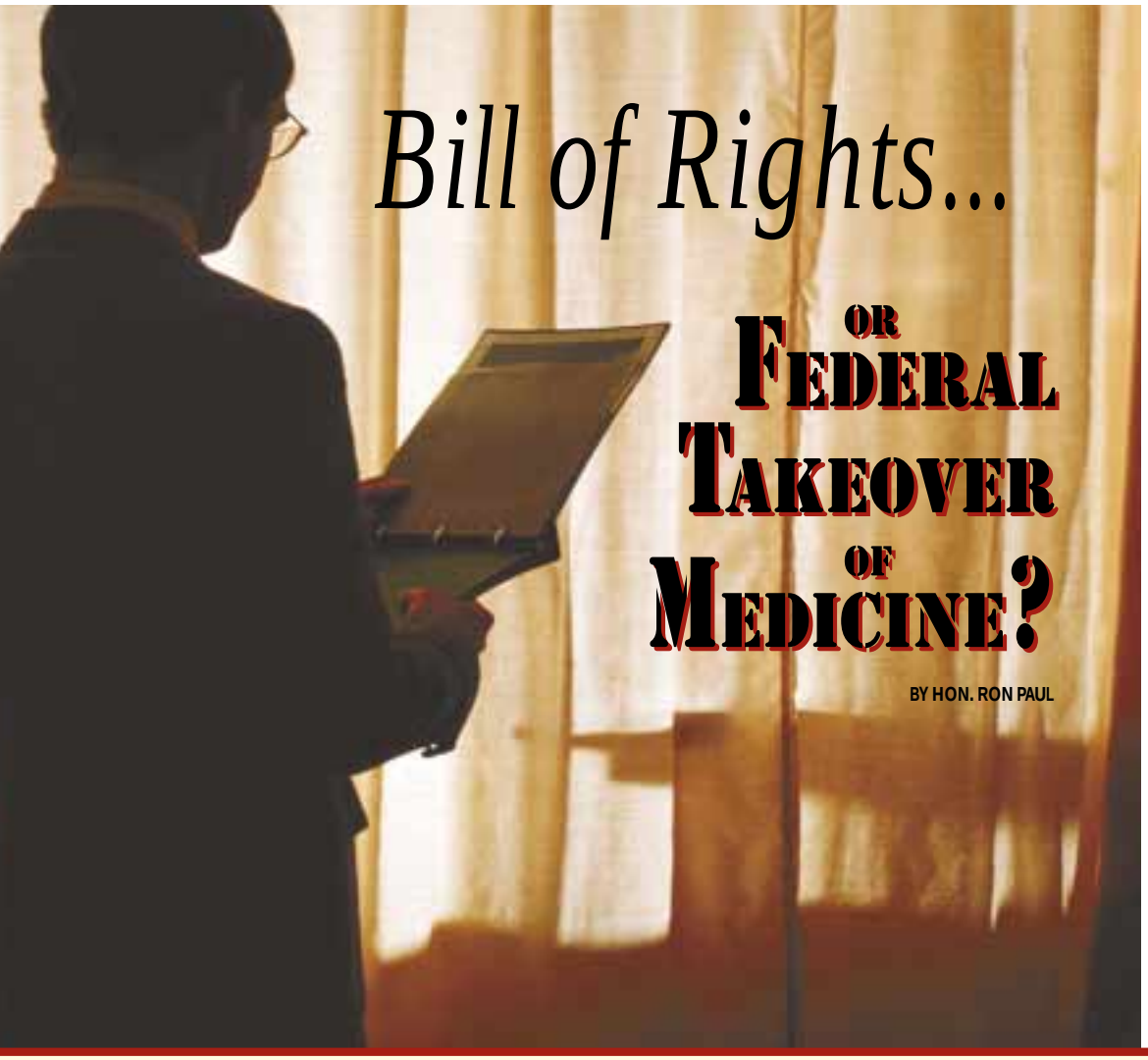

Bill of Rights... or Federal Takeover of Medicine?

BY HON. RON PAUL

For decades, the U.S. health care system was the envy of the entire world. America had the finest doctors and hospitals, patients enjoyed high quality, affordable medical care, and thousands of privately funded charities provided health services for the poor. Doctors focused on treating patients, without the red tape and threat of lawsuits that plague the profession today.

Most Americans once paid cash for basic services, and had insurance only for major illnesses and accidents. This meant both doctors and patients had an incentive to keep costs down, as the patient, rather than a third-party insurance company or government program, was directly responsible for payment. Not coincidentally, there was far less government involvement in medicine during this time. Somehow, however, the clear connection between government involvement in medicine and the decline in our once-proud health care system has been lost in the current debate.

Today most Americans obtain health care through an HMO or similar managed-care organization, or through government Medicare and Medicaid. Since it is very difficult to make actuarial estimates for routine health care, HMOs charge most members a similar monthly premium. Because HMOs always want to minimize their costs, they often deny payment for various drugs, treatments, and procedures. Similarly, Medicare

The Forest vs. The Trees on Patients' Rights

BY JACK FARIS

"Patients' rights" legislation is once again taking center stage in Washington, DC. The new leadership in the Senate is making the curbing of the HMO industry a priority, and the nature of the subject overall is making it news.

Health care affects everyone, so when our elected officials talk (or even just posture) about it, most Americans do, indeed, listen. In that way, health care is unlike so many other issues that are debated in our nation's capital; it is truly important to one and all.

Unfortunately, it is also one of the more complicated policy issues legislators grapple with . . . not to mention one of the most financially significant.

Whether you purchase health insurance on your own, sell health insurance to others, or provide it to your employees, the cost is critical. There are billions of dollars involved: The health care industry as a whole (including not just insurance, but the care itself—doctors, nurses, hospitals, pharmaceuticals, medical supply companies, and on and on) makes up one-seventh of our overall economy. There is much money to be made . . . and to be lost.

And if the money alone didn't make this thing huge, the level of passion surrounding an issue as important as our health has helped turn it into one of the media's favorite issues.

So we read about it in the paper. We see it on TV. And it is still difficult to decipher the "truth" about the "patients' bill of rights."

Is it good for patients or not worth the cost? Is the insurance industry telling the truth? Or are they protecting their enormous assets? Are so-called consumer groups telling the truth? Or are they fronting for fat-cat personal injury lawyers? The forest and the trees become one.

There is one group in the lobbying fray who, I promise you, is not interested in whether they make or lose money. They are only interested in being able to afford health insurance for themselves, their families and, hopefully, for their employees. And they are interested in protecting themselves from being sued for decisions they weren't involved in. Period. Who are these people? They are America's little economic engine-that-could: small-business owners.

They, their families, their employees, and their employees' families represent three-fifths of the nation's 43 million uninsured lives. To them, the so-called "rights" in this legislation are meaningless. Having health insurance is the only thing with real meaning to them, and the "bill of rights" does nothing to help them achieve that dream.

Those in the small-business community who are insured are struggling each year to afford the cost of increasing premiums. The Congressional Budget Office has determined that the "rights" bill will increase premiums an average of 4.2 percent. That number will mean the difference between "insured" and "uninsured" for thousands of these people.

> **"There is one group in the lobbying fray who, I promise you, is not interested in whether they make or lose money. They are only interested in being able to afford health insurance for themselves, their families and, hopefully, for their employees."**

There is legislation in Congress that would address the problem of the uninsured. A new law allowing the creation of Association Health Plans, for example, would help the small-business community in particular. It is therefore disappointing to me that "patients' rights" takes up so many headlines when it really addresses only a small aspect of our overall health care troubles.

If you, like so many Americans, are passionate about improving health care in this country, please take a few moments to look at the big picture, to think about whether "patients' rights" legislation is anything more than just a band-aid that would give a temporary sense of justice and a political feather in the caps of some groups. Think about how we can get this phenomenal free market of ours the chance to lift the quality of the system up while bringing the prices down.

And if you need to sort out the forest from the trees after watching the evening news . . . just ask your favorite small-business owner what the biggest challenges are and what they think ought to be done. They are the real experts.

Jack Faris is president of the National Federation of Independent Business, the nation's largest small business advocacy group. More information is available online at ***www.nfib.com****, or contact Jean Card, NFIB Special Assistant to the President, at 202/314-2018.*

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"Somehow, . . . the clear connection between government involvement in medicine and the decline in our once-proud health care system has been lost in the current debate."

does not have unlimited funds, so it generally covers only a portion of any costs.

Second-Guessed by Middlemen

The result of this system is that doctors and patients cannot simply decide what treatment is appropriate; instead, they constantly find themselves being second-guessed by HMO accountants and government bureaucrats. When a third party is paying the bills and malpractice lawsuits loom, doctors have every incentive to maximize costs and order all possible tests and treatments.

At the same time, patients suffer when legitimate needed treatment is denied. HMOs have become a corporate, bureaucratic middleman in the health care system, driving up costs while undeniably degrading the quality of our medical care.

So what should we do about the HMO mess? Before we call for government action, we should recognize the federal government has virtually mandated HMOs on the American people.

Government Imposed This On Us

First, the tax code excludes health insurance from taxation when purchased by an employer, but not when purchased by an individual. Second, the HMO Act of 1973 forced all but the smallest employers to offer HMOs to their employees. So while many in Congress are happy to criticize HMOs today, the public never hears how the present system was imposed on the American people by federal law.

In fact, one very prominent Senator now attacking managed care is on record in the 1970s lauding HMOs as "effective and efficient mechanisms for delivering health care of the highest quality."

As usual, government intervention in the private market has caused unintended consequences, but Washington blames only the HMOs—not the laws that created them.

Socialized Medicine the Ultimate Goal

Not surprisingly, the loudest voices on Capitol Hill now calling for a so-called "patients bill of rights" don't want to abolish the HMO mandate. Instead, more government is proposed to fix the problem. Congress wants to micromanage the system, deciding what treatments and drugs should be paid for by health insurers. Congress also wants to create new rules allowing lawsuits against *employers* when the HMO refuses treatment to an employee!

Surely the trial lawyers will support the new laws, but Americans should understand that more federal involvement will only increase the cost of health insurance for everyone. Lower-paid workers will find themselves completely uninsured when their premiums increase beyond affordable levels. The truth is that any new legislation will serve only to increase government involvement in our health care system, to the detriment of us all.

Without question, the true goal of some in Congress is to create a system of socialized medicine. It's politically expedient to slap a "patients' rights" label on legislation that simply leads us closer to a complete government takeover of medicine.

We can hardly blame the market for our current health care woes. As with all goods and services, medical care is best delivered by the free market, with competition and patient responsibility keeping costs down.

Unleash the Free Market

Government has neither the constitutional authority nor the wisdom to determine appropriate contract terms between individuals and health insurers. Congress needs to abolish the HMO mandate and allow favorable tax treatment for individuals paying for health care directly. Medical Savings Accounts (MSAs), tax-deductible and tax-exempt accounts used to pay medical expenses, should be made available to all Americans.

When patients spend their own money for health care, they have a direct incentive to negotiate lower costs with their doctor. When government controls health care, all cost incentives are lost. No "patients' bill of rights" will help us when the money runs out.

Ron Paul is U.S. Representative from the 14th District of Texas. This essay is from his weekly column, Texas Straight Talk, *July 2, 2001. You can access his views on Texas Straight Talk archives at* ***http:/www.house.gov/paul/tst/welcome.htm****.*

Patients' Bill of Rights An Unhealthy Remedy

BY ROBERT MOFFIT

In an effort to help Americans unhappy with the service they're getting from "managed care" health plans, federal lawmakers are laboring mightily to enact a "Patients' Bill of Rights" that would let patients sue those plans when they feel they've been mistreated.

The details have yet to be hammered out, but one way or another, more lawsuits seem imminent.

Trouble is, lawsuits won't cure what ails our health care system. Indeed, increasing the likelihood of lawsuits could do some serious harm, as health maintenance organizations (HMOs) respond to the prospect of higher legal expenses simply by increasing premiums. That would force many employers to make their employees pay even more for health care. Worse, some employers may find it necessary to drop coverage altogether.

A better solution is available to us. It's the same one that gave us 5-cents-a-minute long distance, $10 overnight shipping to anywhere in the world, and 59-cent cheeseburger day at McDonald's: Free-market competition.

Let Employees Choose

Let workers choose their HMOs—rather than be required to take the one their employer picks—and watch the difference. Some plans will keep costs down but remain as maddening as they are now. Others will be more expensive but offer better service. Some will fall somewhere in between. Still others will go out of business.

And soon Americans will have something they don't have now: A real choice.

More than 90 percent of Americans with health insurance—HMOs or otherwise—are covered through their employers. Fewer than half have any choice among plans. And even for those lucky few, the list of choices is short, and the employer makes the list.

Given that most workers have the option of accepting their employers' insurance or having none at all, it's no surprise some are dissatisfied with their employer-sponsored plans and—understandably—feel frustrated when they can't do anything about them.

The object of health care policy should be to make it easy for consumers to find coverage that meets their needs, and to arrange for that coverage without going through their employers.

If Americans had real choice, insurance companies would have to compete for their business on the basis of consumer satisfaction. That alone would solve the problem a "Patients' Bill of Rights" is supposed to address . . . without extra lawyers, who ought to be a last resort for disgruntled patients.

Promising Reforms

Two alternatives to what Congress and the administration are proposing would give Americans the decision-making power they currently lack.

One is to allow employers to take the money they currently pay in health insurance premiums and instead offer their employees "defined contributions": an amount employees can use to buy their own health insurance coverage.

Defined-contribution plans would work much like 401(k) contributions do. Employers handle the paperwork, but leave the important decisions to their employees. Employers merely send a check—which includes their contribution and the employees' contribution (withheld, as now, from their paychecks)—to the insurance company chosen by each employee.

Everyone wins. Employees get the coverage they want, and employers stop shopping for insurance.

The second alternative would help workers whose employers don't offer health insurance—an audience ignored by the legislation now before Congress. Lawmakers should offer them refundable tax credits. Doing so would give lower-income workers, who make up most of the uninsured, access to comprehensive health benefits.

Research shows that tax credits would make health insurance more affordable and accessible. Roughly three out of every four health plans charge premiums equal to or less than the tax credit amounts called for in the leading proposals.

Tax credits also would give employees and their families the leverage a "Patients' Bill of Rights" is meant to provide. Employees who buy plans directly from insurers become party to the contract. If insurers don't live up to the contract, employees can sue . . . but that would likely happen only as a last resort.

The nature of competition means lawsuits would occur far less frequently under a tax credit plan than they would under a "Patients' Bill of Rights." HMO officials wouldn't have to be *forced* by lawsuit to become more responsive. They'd do it because it's in their competitive self-interest.

Lawmakers may think they're doing patients a favor by letting them sue their way to good health, but they've made a serious misdiagnosis. Let's hope they're willing to consider a second opinion.

Robert Moffit is director of domestic policy studies at The Heritage Foundation, a public policy research institute. He can be reached by email at staff@heritage.org.

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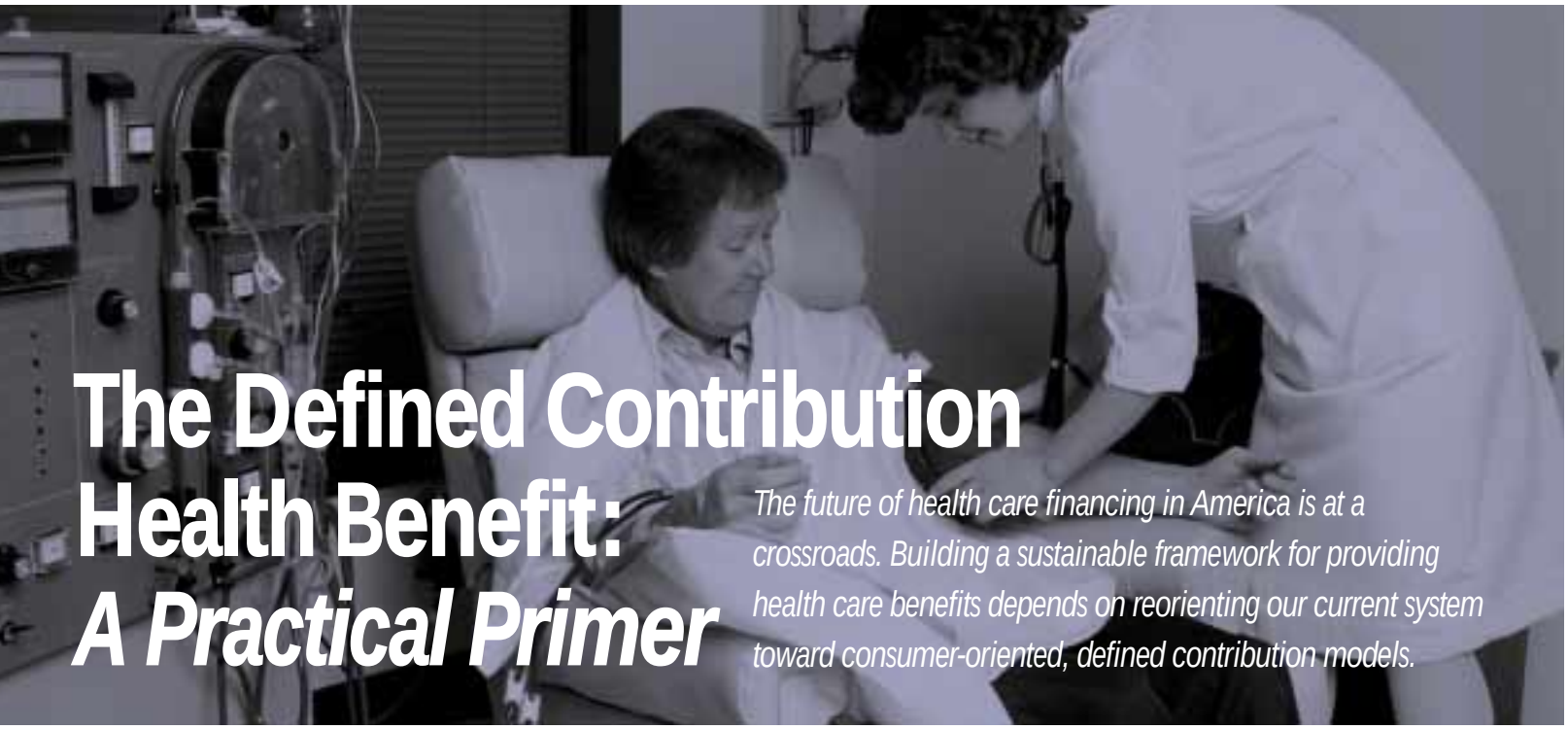

The Defined Contribution Health Benefit: *A Practical Primer*

The future of health care financing in America is at a crossroads. Building a sustainable framework for providing health care benefits depends on reorienting our current system toward consumer-oriented, defined contribution models.

BY STEPHEN BARCHET, M.D.

A defined contribution approach to health care creates a new, more sustainable financial framework for an employer seeking to provide its employees with health benefits and purchase health plan coverage. This framework establishes clearly and predictably how much the employer will contribute to benefits.

In its fullest expression, the defined contribution also distances employers from health plan selection. It permits employees to directly control the range of health plans they may consider, producing a real sense of ownership over their eventual plan choice.

A defined contribution approach has the following main features:

- Fixed employer contribution. The employer decides upon a fixed amount to pay for health plan coverage for all employees.
- Many plan options. The employer presents employees with a choice of different health plans with varying deductibles, co-payments, health management styles (health maintenance organizations versus preferred provider organizations), and premiums.
- Employee selects plan. Employees choose from the menu of health plans available and presented by the employer.
- Employee pays difference. Employees pay the difference between the amount contributed by the employer and the cost of the coverage for the plan they select.
- Employer pays health plan. The employer pays the premium for coverage directly to the health plan.
- Employee controls coverage. Employees are free to remain with the health plan they initially selected or seek another health plan that better meets their needs.

In a defined contribution approach, employer contributions for health benefits are clearly labeled a part of total compensation for employees. Each employee is compensated with a fixed contribution. The fixed contribution generally is determined by the employer and can be based on a large number of considerations allowed under current law and regulations.

They can include the historical level of the health plan premium, a fixed annual percent increase such as 5 percent, a variable amount based on health cost increase trends, and/or any variation based on profitability, net revenue, productivity improvement, or other economic or performance-related measure.

Under the defined contribution approach, an employer can make the amount of the defined contribution equal for each employee or vary it based on a variety of factors such as number of family members, job classification, performance appraisal results, length of employment, divisional performance, or additional factors allowable under existing benefit laws and regulations.

When given a *choice*, some employees prefer to take a plan with higher co-pays or elect to change doctors or use their spouse's health benefit plan. But employees rarely are given these options in the typical group plan offered by small employers. Instead, the employee must select one health plan with limited benefit coverage and point-of-use cost sharing—in addition to the inevitable, irritating administrative requirements. Employee choice of health plans consistently emerges as one of the most highly valued features of a benefit program.

Our current health benefits arrangements are contributing to the rapidly escalating cost of health plan coverage. Furthermore, the rate of increase for health coverage is far higher than all other cost increases for most employers. This rapidly growing component acts to reduce the funds available to pay cash compensation to employees or provide other benefits and, on a global level, reduces the competitiveness of the products and services of American companies. This situation is not sustainable over the long haul for either small employers or their employees and family members.

If employers and employees hope to maintain long-term satisfaction with their health coverage, a positive alternative in offering and paying for health insurance is badly needed. A

CONTRIBUTION continued on next page

"If employers and employees hope to maintain long-term satisfaction with their health coverage, a positive alternative in offering and paying for health insurance is badly needed."

For more information…

WWW contact Lynn Harsh, executive director of the Evergreen Freedom Foundation, at 360/956-3482 or email effwa@effwa.org. The full text of Dr. Barchet's report is available for a suggested contribution of $25; an online ordering form can be found at **http://effwa.org/website/DCHBorderform.htm**.

Figure 1 Possible Health-Plan Selection Criteria

Additional payroll contribution amount
The amount required to be paid by the employee beyond the defined contribution provided by the employer. This would generally be prorated—the total amount divided into the number of pay periods per year.

Provider choice options
This identifies providers that can be used under the health plan's provisions without any financial penalty This criterion applies to all types of health care providers covered under the provisions of the health plan with particular relevance to providers currently used by the beneficiaries. The higher the degree of patient allegiance to the health care provider currently used the more important this particular criteria will be in the plan selection process.

Point-of-use cost sharing requirements
These include the amounts the beneficiary pays when using services under the health plan. Usually in the form of deductibles, co-pays, co-insurance, and annual out-of-pocket maximums for specific services.

Level of catastrophic protection
The total amount of individual and family financial protection in a year and the lifetime maximum coverage tinder the plan.

Reputation of the health plan
The general opinions about the health plan as expressed by friends, co-workers and others.

Health plan report card performance
If "report cards" are available, each health plan is compared to others. May include Health Plan Employer Data Information Set (HEDIS) information on the performance of the various health plans.

Breadth and depth of covered services
The range and depth of benefits coverage or covered services under the health plan.

Extent of preventive care coverage
The breadth and depth of coverage for clinical preventive services under the health plan.

Financial strength and stability
The financial soundness of the health plan including its track record and stability. Includes HEDIS elements.

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CONTRIBUTION continued

"defined contribution" approach is a workable and positive solution. It involves employees more directly in the process of selecting and paying for health coverage, and it can be structured and implemented with considerable flexibility. With defined contribution, the employer may customize the company's benefits-compensation strategy and offer a plan that meets its needs and employees' needs.

Many Options

Employers have four options in providing employees a choice of plans:

- Group health plans
- Individual health plans
- Group and individual health plans
- Allow individuals to find their own health plan

OPTION ONE: Group policies typically have more lenient underwriting provisions (that is, coverage is more readily available to employees with health problems), more generous contract provisions, and/or lower cost. Group policies usually require most if not all eligible employees to participate, and many insurance companies are not eager to give employees in small companies a choice of plans.

OPTION TWO: The employer provides access to a number of individual plans. The employer does not have to worry about participation requirements and can usually offer more choices to employees. Employees own the policies, so each policy is fully portable.

OPTION THREE: The employer offers both group and individual policies.

OPTION FOUR: The employer provides individual employees with the choice of finding their own health plan. Employees might select from among traditional indemnity plans, preferred provider organizations (PPOs), point-of-service (POS) plans, and health maintenance organizations (HMOs).

Employee Selects the Plan

Under a defined contribution approach, each employee can choose from the health plans offered by the employer the one that best fits his or her individual circumstances. The employer may decide to make information from a number of health plans available to employees in a standard format for comparison. Employees may select their health plan based on any number of criteria, such as those outlined in Figure One.

Employees are likely to be more satisfied once they have the ability to choose, especially when their decisions are supported by reliable and relevant information about the features and characteristics of each health plan. The company's personnel compensation staff can coordinate the plan selections, insurance company billings, and monthly premium payments, or the company may choose to hire an outside administrator to manage the process.

Stephen Barchet, M.D. is manager of the Defined Contribution Project at the Evergreen Freedom Foundation. This summary is taken from his Defined Contribution Health Benefits: Enabling Employee Choice. A Practical Primer for Employers, *published in April 2001 by Evergreen.*

THE GALEN REPORT

A monthly review of health policy matters

In "Importing HCFA-Style Regulation Into the Private Sector Through The Patients' Bill of Rights," Robert E. Moffit of The Heritage Foundation looks beyond the litigation aspect of the patients' bill of rights and examines the regulatory implications.

"If enacted, the Senate bill, like the House versions, would have a massive impact on the structure and functioning of the American health care system. Beyond the highly visible issue of litigation, the legislation would extend federal rules, guidance, or control over virtually every major aspect of private health plan operations," he writes. "The accumulation of these provisions is tantamount to a massive transformation of private health insurance into something more akin to a public utility."

Moffit's paper incorporates a previously published analysis by health care attorney John S. Hoff. Moffit compares the regulatory schemes in the House and Senate versions of the bill and warns of the sweeping control the federal government will gain over private health insurance, which, if the bill becomes law, "is likely to be 'private' in name only."

For more information . . .
The full text of Moffit's paper can be found on the Heritage Foundation Web site at
http://www.heritage.org/shorts/20010627pbormemo.html

Fundamental System Change Needed

Beyond the Patients' Bill of Rights
Author: Daniel H. Johnson Jr., MD
Source: The Wall Street Journal, 7/10/01

Lawmakers must move beyond the patients' bill of rights and make changes that will promote consumer-driven health care, says Stormy Johnson, former president of the American Medical Association and visiting fellow at The Heritage Foundation. The core problem is that most Americans receive health insurance selected by their employers and therefore have little control over their coverage.

"When employees are denied some desired benefit by a plan they didn't choose in the first place, they are understandably angry," Johnson says. "When a physician is told what to do by someone 2,000 miles away, the physician is apt to be irate." Americans must be able to see the "true costs of their medical care," lawmakers should change the tax laws, and new purchasing mechanisms should be set up to create a consumer-driven system.

For more information . . .
The full text of Johnson's article is available at the *Wall Street Journal*'s Web site at
http://interactive.wsj.com/archive/retrieve.cgi?id=SB994727391212554351. Registration and a fee are required.

Pfizer Partners with State of Florida

Pfizer Avoids Pressure on Prices By Helping Florida on Medicaid
Authors: Russell Gold, Scott Hensley, and Joni James
Source: The Wall Street Journal, 7/9/01

The Wall Street Journal reports that Pfizer Inc. and the state of Florida have entered into a "novel pact" to deal with the state's rising Medicaid costs.

In exchange for getting all of its drugs onto Florida's formulary without rebates, Pfizer negotiated an agreement with Gov. Jeb Bush for an innovative program to provide health care services in lieu of price discounts. Pfizer says the agreement will save Florida's Medicaid program $33 million over two years.

The company will hire nurses to monitor the care of tens of thousands of patients, especially those with chronic illnesses, through a disease management program. If the savings don't materialize, Pfizer will pay the difference.

For more information . . .
see the Kaiser Daily Health Policy Report summary at
http://www.kaisernetwork.org/daily_reports/rep_hpolicy_recent_rep.cfm?dr_cat=3&show=yes&dr_DateTime=09-Jul-01#5665

Lessons from Europe

Perspectives on the European Health Care Systems: Some Lessons for America
Authors: Robert E. Moffit Ph.D., Philippe Maniäre, David G. Green Ph.D., Paul Belien, Johan Hjertqvist, and Friedrich Breyer Ph.D.
Source: The Heritage Foundation

The Heritage Foundation and the Centre for the New Europe cosponsored a conference in Washington this spring to assess what Americans can learn from the European experience in health care and pension policy. This paper offers presentations by health care experts from France, Great Britain, Belgium, Sweden, and Germany and should be a mandatory read for anyone who thinks socialized systems are the answer.

The experts each offer lessons that should be heeded by U.S. policymakers as the information age, medical innovation, and consumer empowerment begin to collide with centralized control-and-command systems. The Galen Web site will soon have a more complete report on this important conference and paper.

For more information . . .
The full text of the article can be found on The Heritage Foundation Web site at **http://www.heritage.org/library/lecture/hl711.html**.

Defending Pharmaceuticals

New Drugs: The Right Remedy
Authors: Frederick Goodwin and Robert Goldberg
Source: The Washington Post, 7/7/01

Frederick Goodwin and Robert Goldberg discuss flaws in an earlier commentary article in the *Post* by physicians Marcia Angell and Arnold Relman, "Prescription for Profit."

Angell and Relman echoed the claim of many liberals that drug companies have excessive profits, more than are needed to finance their research. Goodwin and Goldberg point out, "Only the top 10 percent of all drugs actually bring a return on investment," and the real return is only about 9 percent, not the 20 percent Angell and Relman claim. The two also ignore studies showing "the value of increased pharmaceutical investment, research, and drug utilization." Frank Lichtenberg of Columbia University, for example, shows cost savings and other benefits of existing drugs.

For more information . . .
The full text of the Goodwin/Goldberg article is available on the *Washington Post*'s Web site at **http://www.washingtonpost.com/wp-dyn/articles/A29895-2001Jul6.html.**

The Galen Report is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA, 22320. Grace-Marie Arnett, president. The report is compiled by editor Liz Turner. Turner can be contacted at 703/299-9550, or visit the Galen Institute Web site at http://www.galen.org.

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The Structural Problems of Single-Payer Systems

BY RICHARD TESKE

The promises made by proponents of a single national health system always sound so much better than the reality. That is the Faustian bargain of all socialized economic systems. Those systems may start out in different places, but they always end up in the same place: price controls, rationed access, and second-tier quality. The reason for this is very simple.

The Problem Is Structural

There are three elements to every health system: cost, access, and quality. How you handle those three elements determines a system's structure and outcome. In the old Soviet-style health systems, for example, in order to preserve egalitarian communist access and to control costs, quality was sacrificed. Look at Cuban health care today.

The socialized systems of democratic countries, in Canada and Western Europe, took a different approach. In order to control costs but keep quality high, they rationed access to care.

In America, we wanted both universal access and high quality, regardless of cost. For Medicare and Medicaid, the result was inevitable: Costs soared. In their first year of operation, 1967, both started as $1 billion programs. Today, Medicare is a nearly $300 billion program, and Medicaid is over $200 billion.

Exploding Costs

Wilbur Cohen, a former Secretary of Health, Education, and Welfare and also one of the chief architects of the Social Security Administration, Medicare, and Medicaid, explained the reason for Medicaid's uncontrolled growth: "Many people since 1965 have called Medicaid the sleeper in the legislation. Most people did not pay attention to that part of the bill. It was not a secret, but neither the press nor the health policy community paid any attention to it."

President Lyndon Baines Johnson, author of the Great Society programs, was calling attention to the cost overruns even before he left office in 1969. We were spending by 1970 what was projected to be spent in 1990.

In the 1970s, we instituted health planning areas, certificates of need, peer review, wage and price controls, and construction moratoriums on hospitals and nursing homes. In the 1980s, we tried new federalism, program swaps, deregulation, and, for Medicare and Medicaid, hospital and physician fee freezes, and then national fee schedules. In the 1990s, we tried targeting government entitlement programs to specific new populations: pregnant women, children, and the uninsured, for example.

Rationed Care

In the private health care arena, we turned to "managed competition" as the solution *du jour* in the early 1990s. In reality, managed competition was neither managed nor competitive. It was a slow path to the conclusion of socialized entitlement programs: rationed care.

The problem is structural. Our government-run health care programs are *defined benefits* programs. In such programs, the bureaucratic levers to control access, quality, and costs are changes in eligibility, benefits, and reimbursement.

In a defined benefits program, eligibility and benefits are fixed and universal. It's *costs* that are variable. If you are eligible for the program, you are entitled to all the benefits, regardless of the costs to the government or the taxpayer. Thus, the name "entitlement program."

Politically, it is almost impossible to cut benefits or eligibility in a defined benefits program. The pressure is always in the opposite direction: Note the present pressure for expanded benefits like pharmaceutical coverage, or moves to guarantee access, like the patients' bill of rights.

So it usually falls on providers and reimbursement to control costs. But wage and price controls, no matter what their name, always have an impact on quality. And eventually, the effect is to ration access to care. This devolution into a rationed and price-controlled system with poor quality in America occurred first in Medicaid.

As John Iglehart, the editor of *Health Affairs*, has said, "Medicaid's architects," of which Wilber Cohen was one, "envisioned a program that would provide poor people with mainstream medical care in a fashion similar to that of private insurance. As the decades have passed, that vision has largely faded, and several tiers have emerged. Mainstream medical care is provided to people with Medicare and to people with private insurance, but poor people must continue to rely on second-tier providers that make up the nation's medical safety net. Medicare is following Medicaid down the same path to rationing and diminished quality of care."

> **"If we don't turn to this defined contribution approach, we will be stuck with a socialist, defined benefits welfare entitlement approach."**

Future Shock

The revolution in the information technology field is taking us to a brave new world where, as I call it, the chip marries the cell. Most troubling is that the financing of our entire health care system may collapse with the cost of new scientific discoveries such as the mapping of the human genome, stem cell research, slowing the aging process, and cloning. The costs will be as astronomical as the philosophical questions.

The aging of the population means an absolute and real fivefold increase in long-term care spending by the year 2020. Note that half of all long-term spending comes from Medicaid. Also note that one-fifth of all present state spending is for Medicaid. If you multiply 20 percent times 5, you come up with 100 percent. This means the Medicaid program and long-term spending, unless current institutions change, could bankrupt every single state government within a generation.

A New Approach

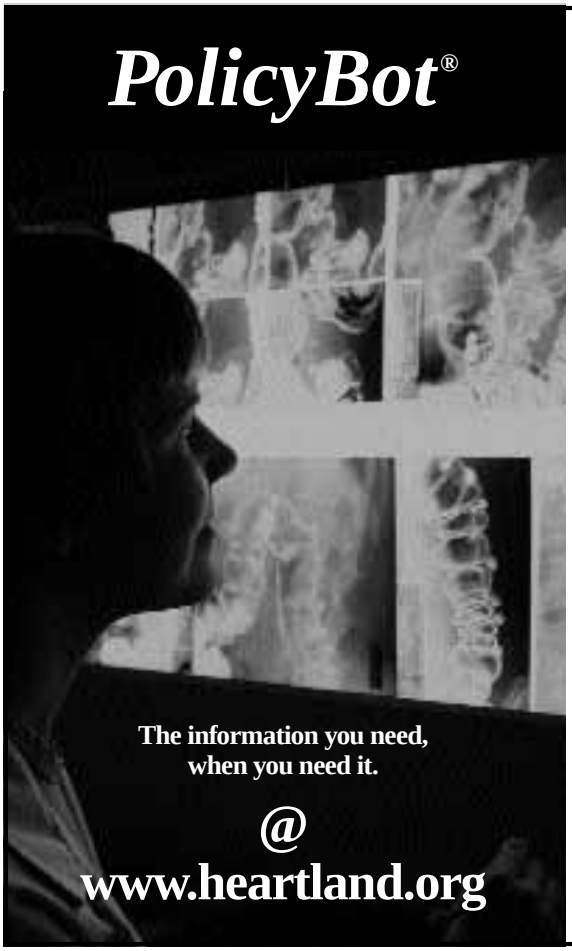
At the end of the day, there is only one structural alternative to the current defined-benefits approach to health care finance and delivery: a consumer choice-oriented, market-based plan called the *defined contribution* approach. In the defined contribution approach, costs and eligibility are fixed. It is the *benefit* that is variable.

We have already seen an approach like this take hold in the private pension arena. In the old days, everybody's pension plan was designed to deliver a defined benefit. So many years, so many this, so many that: one size fits all. It was not sustainable. Employers have moved to a defined contribution approach, where they gave you a defined contribution, called a 401(k) in most instances, and said, "Okay, here is your money. You invest it the way you want to. This is my contribution to your retirement. I'm not going to guarantee a certain payout at a date certain through this old defined benefit program."

We've already done it in pensions, and it's now time to do it in health care. A system broadly similar to the Federal Employees Health Benefits Program for private and public health care programs is the only philosophically coherent and politically viable alternative to single-payer plans.

Make no mistake: There are no halfway measures. Socialism and liberty are incompatible. If we don't turn to this defined contribution approach, we will be stuck with a socialist, defined benefits welfare entitlement approach. It will be our very best plan—unless you have to use it.

Richard Teske, an expert on Medicaid, Medicare, long-term care, and reform for the uninsured, is the former Official Liaison to the White House for Health and Human Services. This article is based on a Heritage Foundation Lecture published February 13, 2001.



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PHARMACY SUIT continued from page 1

The NACDS is the country's largest pharmacy organization, serving nearly 170 members, including traditional chain pharmacies, supermarket chains, and mass merchandisers as well as nearly 1,400 affiliate members. The NCPA represents the pharmacist owners, managers, and employees of nearly 25,000 independent community pharmacies across the United States.

The two groups have filed suit to prevent the Bush administration from promoting prescription discount cards in the Medicare program. They allege the Bush plan is "clandestine and unlawful" and would force them to bear the burden of trimming the cost of medicines for anyone insured by Medicare.

Unlawfully Adopted

According to the complaint, Congress did not authorize HHS to move forward with the drug discount initiative, as required by law. The Administrative Procedures Act requires that HHS be authorized by Congress to set standards and expend funds for such programs. Moreover, HHS is required by provisions of the Federal Advisory Committee Act to hold open meetings, for which prior notice has been given, in the development of government programs.

For more information…

WWW The full text of the NACDS/NCPA suit is available on the Internet at **http://www.nacds.org/user-documents/DiscountCardLawsuit.pdf**. Additional information about the suit is available on the NACDS Web site at **http://www.nacds.org**. The NCPA also has a Web site, at **http://www.ncpanet.org**.

Instead, according to a NACDS news release, "the administration privately met with major Pharmacy Benefit Managers (PBM) in hopes of creating a short-term prescription benefit plan for needy seniors." By setting up the consortium of PBMs to create, administer, and enforce the drug initiative's standards, HHS unlawfully delegates power to a private company, the NACDS alleged.

Wrong Solution

White House officials said the administration could begin the new program without congressional approval as early as this Fall. The initiative would endorse and promote through Medicare several privately administered prescription drug discount cards, like those currently offered by pharmaceutical and other companies. At most, the cards would cost senior citizens $25; in many cases, they would be free. The administration says Medicare recipients would save 25 percent on typical pharmacy purchases, and as much as 50 percent for mail-order drugs.

But Craig Fuller, president and CEO of the NACDS, warned the administration against developing "false hopes" in senior citizens. He told the Associated Press, "This plan provides false hopes to our seniors when they walk into their neighborhood pharmacy. The possibility exists that there are no real discounts on the drugs that their doctors prescribe."

Calvin Anthony R.Ph., executive vice president of NCPA, agreed. "The evidence is already abundantly clear that discount plans like this don't work," he said. "They've been outlawed in more than a half dozen states and abandoned in many others. This is a misguided approach to a serious problem."

"The two groups . . . allege the Bush plan is 'clandestine and unlawful' and would force them to bear the burden of trimming the cost of medicines for anyone insured by Medicare."

The NACDS/NCPA suit asks the court to declare the Medicare Rx Discount Card Program to be illegal and to preliminarily and permanently enjoin the Secretary and the Administrator from implementing the Card Program.

In a series of "talking points" posted on its Web site, the NACDS explains its opposition to the prescription card plans:

- Prescription discount card programs are not coverage programs. They "overpromise" and "underperform."
- A discount is of no value to a senior citizen who has no means to pay for his or her prescriptions.
- The discounts offered under card programs come entirely from reductions in the prices charged by pharmacies—not from price reductions by drug manufacturers.
- Seniors who enroll in a card program may pay not only an enrollment fee, but also higher prices for their prescription drugs. Local pharmacies often charge lower prices for prescriptions than are charged by the major pharmacies that offer drug cards. An analysis of Washington State's AWARDS prescription discount program found that for 235 drugs commonly prescribed for the elderly, AWARDS had the lowest prices in only seven instances. A state court struck down the program in late May.

Seeking Fuller Coverage

NACDS' Fuller said the organization supports "true Medicare reform and the need to provide a Medicare benefit that covers the cost of prescription drugs." For NACDS and other pharmacy organizations, that means "a 'pharmacy benefit' for the nation's seniors—ensuring that they receive the necessary medications as well as the important counseling and services that only a community pharmacist can offer."

"What seniors need is a true pharmacy benefit that guarantees them access to the valuable professional services offered by local pharmacies all across America," said NCPA's Anthony.

Single-Payer No Guarantee of Quality Care

BY CONRAD F. MEIER

Single-payer health care systems are frequently proposed as the solution to the problem of health care access for the uninsured.

While single-payer plans *can* guarantee that all citizens have a health insurance policy, they *cannot* guarantee access to medical care—much less prompt delivery of quality care to provide desirable medical outcomes.

Many nations have gone the single-payer route. From their experiences, we know single-payer plans inevitably control costs through a global health care budget…which means rationing of care and limited access to cutting-edge medical technology. Government-run health care systems are bureaucracies wrought with high and hidden administrative costs. As they bloat, more tax dollars are needed to support them, and taxpayers get less accountability in return.

During the last two legislative sessions at the state level, grassroots activists sought legislation or launched single-payer ballot initiatives in Alaska, California, Colorado, Florida, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, New York, and Oregon. For the most part, those initiatives failed.

In Washington State, where single-payer most recently failed, Initiative 245 would have created a system in which a new state government entity would pay for basic health care for every state resident. The $10.4 billion plan would have been financed by a new business tax and premium payments or payroll taxes on individuals; governed by an unelected board; and not subject to normal appropriations or oversight processes.

The Universal Myth

Despite the failure of many state initiatives, and the dramatic failure on the national level of the Clinton administration's single-payer proposal, the Health Security Act of 1993, the states continue to test their waters for interest in single-payer health care. They inevitably phrase their survey questions and stump speeches to claim single-payer plans have the advantage of being universal: They serve everyone. Yet single-payer health care is anything but universal, in its approach or in its delivery of health care.

Single-payer plans inevitably exempt some employers from the tax required to fund the plans. Among those typically exempted are government entities: public schools, colleges, and universities; local fire and police departments, the city council, county board, and other governing bodies; local taxing districts; and, of course, the governor's office and mayors' offices across the state.

The workforces laboring for exempt employers are nevertheless eligible for benefits under single-payer proposals. In a government-run system of health care, then, the burden of paying for the system is borne entirely by those who are not government employees.

We Have Been Warned

Some countries with single-payer plans have experienced health care inflation lower than the double-digit growth experienced in the United States. But in order to hold costs down, virtually all decisions with regard to health care services and pricing are made by a centralized government bureaucracy. Here in the United States—with managed care, Medicare, and Medicaid—we've had only the smallest taste of the intrusiveness that accompanies a single-payer health care system.

Imagine being allowed to buy a car from only one manufacturer, or allowed to purchase your groceries from only one supermarket. What would happen to the innovation and customer-responsiveness that now characterize those industries? Single-payer means dramatically limited choices for consumers, and that discourages creativity, risk-taking, efficiency, and quality among providers.

Government-run health care has its roots in nineteenth century European socialism. That alone should be a warning to policymakers considering single-payer proposals.

"We have become a prosperous nation by separating the economy and the state, not by making the state the source of employment, as have the communists, with the disastrous results known to all," writes Dr. Thomas S. Szasz, professor of psychiatry emeritus at New York Upstate Medical University, in the Spring 2001 issue of *The Independent Review*. "We can become a healthy nation only by separating medicine and the state, not by making the state the source of health care, as have the communists, with similar disastrous results."

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Telling it Like it Isn't

BY MICHAEL ARNOLD GLUECK, MD
AND ROBERT CIHAK, MD

Economist Thomas Sowell recently wrote a column aimed at a chronic affliction in journalism: the lack of integrity by some editors and writers.

In the pursuit of an agenda or lack of critical evaluation, statistics and facts are often skewed or reported without question. And, throwing honesty to the wind, writers fail to properly attribute material back to its source, thus pinching the observations and reporting of fellow writers.

As the relatively new kids on the block of national journalism, we have diagnosed the same maladies in the coverage of medical issues by the press—even in some of the self-acclaimed "prestigious" medical journals.

Fiction Becomes Fact

In his commentary, "Lying Statistics," Sowell begins by discussing "innumerable erroneous statistical claims generated by advocates of one cause or another. Too often, those in the media who are sympathetic to these causes repeat such claims uncritically until they become 'well-known facts' by sheer repetition."

> **"In the pursuit of an agenda or lack of critical evaluation, statistics and facts are often skewed or reported without question."**

He writes further, "Hysteria sells and accuracy takes time, which could make the news stale by the time the statisticians check it out."

He concludes, "The one thing that all these distortions and falsifications of statistics have in common is their thrust in the direction of creating artificial 'problems' and 'crises' to be dealt with by imposing government 'solutions.' That is apparently what makes them so attractive to the media that these shaky numbers are uncritically accepted and proclaimed to the public."

See No Good, Hear No Good

Our own education involving "statistics hysteria" and "non-crediting" of sources began late in 1999. Our initial observations were noted in a January 23, 2000, *Orange County Register* guest commentary.

We feel the *Register* is one paper that demonstrates true editorial integrity. Its freedom mission, goals, and objectives are clearly defined and stated. Its outstanding editorial page editors, Cathy Taylor and Matt Leone, are not afraid to publish differing opinions from contributors and readers.

Our commentary, "Medical diagnosis: crying like a wolf?" looked at an Institute of Medicine report, leaked late in 1999, which scared the socks off the public, claiming between 44,000 and 120,000 medical patients die annually because of human error. The report was, of course, widely sensationalized by the media, with no discernable voice of doubt from the nation's press corps.

As we wrote then, "offering a range of 40,000 to 120,000 deaths is hardly precise. We also note that even the lower end of this range is three times higher than the National Safety Council estimate." After floating the high numbers, the IOM recommended the creation of "incentives that will lead to a safer health care system," suggesting a new federal bureaucracy called "A National Center for Patient Safety."

"Until we get all the facts and the data undergo scrutiny and analysis," we concluded in the *Register* piece, "perhaps we should declare a temporary moratorium on worry for the patients of this country. . . . Our modest proposal is for everyone to stop crying wolf."

A few weeks after our column ran in the *Register*, many of the big papers, famous op-ed pages, and some prestigious medical journals suddenly rewrote their columns to conform to the new worldview, which said the medical error alarm was not as loud as originally sounded. And to our non-surprise, no one referenced or credited our article.

We expected this from the general press, but were somewhat taken aback by the medical journals' oversight. After all, these writers, to the point of paranoia, reference every single word down to the exact author(s), title of article, journal, edition, volume, page, and sometimes paragraph. The reference list often takes longer to prepare than the article itself!

Learning Some Lessons

Given the fact that journalism schools are producing generalists without any grounding in health care issues, it is not surprising the public is dangerously misinformed on the issues. The misinformed then vote on issues of importance.

The commonality of Sowell's and our observations is the lack of honest, objective, and knowledgeable reporting by some writers and editors in pursuit of an agenda.

We live in a media world where it seems everyone exaggerates and "borrows" from each other. Can we at least agree to a few simple rules and manners?

We don't ask that daily journalism switch to the medical style of journalism, with its suffocating peer review and endless bibliographies. But, we all can check statistical sources and actually read the reports, studies, and bills we comment on.

Take, as an example, the 175-page "Patients' Bill of Rights" (PBOR). It becomes quite clear, after reading many of the mainstream press's reports on the bill, that most editorial pundits didn't read it . . . as they usually don't, if the source is more than a few pages.

Had they read the PBOR, they might have disclosed the following shocking information reported by Conrad F. Meier, managing editor of *Health Care News:*

"Over 45 million seniors insured by Medicare will not be able to file suit against the government for alleged denial of claims. Another 20 million Americans insured by Medicaid; 3.2 million VA beneficiaries; 7.3 million children covered by the Children's Health Insurance Program; and over 3 million government employees insured in the Federal Employee Health Benefits Plan would also be excluded from the Bill of Rights' mandates, directives, and litigation provisions."

As for not ripping off our fellow wordsmiths, we can easily do a better job of in-article crediting of our sources. All we ask in return is for anyone who follows our lead to at least spell our last names correctly.

Michael Arnold Glueck, M.D., writes on medical, legal, disability and mental health reform. Robert J. Cihak, M.D., is president of the Association of American Physicians and Surgeons (AAPS). They write regularly for WorldNetDaily and Health Care News.

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Social Security Health Benefits Need Revision

BY DEWEY CREPEAU

The whole concept was new to me.

As a young, first-year associate over 20 years ago, I was given a file for a trial to be held later that day before a United States Administrative Law Judge. One of our clients had been injured and could not work any more. It was my job to convince the judge the man was disabled within the meaning of federal law. Thus was my introduction to the world of Social Security Disability.

We all know about Social Security, as in retirement and Medicare. Using its taxing authority, the federal government retains 15.3 percent of the self-employed's income, or the same percentage split equally between an employer and employee, to fund these massive programs. But unless you are disabled, you may not know that a portion of these taxes also fund a program for the disabled. Currently, more than 5 million people receive Social Security Disability benefits.

Wonderful, say you. "If I become disabled before I reach retirement age, Uncle Sam will be there to provide for me." Not necessarily. Consider the hoops you have to jump through after being compelled to pay for disability coverage throughout your working life.

Jumping through Federal Hoops

The average monthly benefit is about $790. Even the maximum is only about $1,300, although children in the family can increase the amount paid somewhat. In order to receive that check you must be unable to do any type of substantial gainful employment. A university professor who suffers a brain aneurysm but retains the mental and physical ability to do repetitive light factory work would not qualify for benefits.

An ironworker, making $25 per hour, with a job-ending back injury but still physically capable of working full time at a parking garage taking tokens, or being a theater usher for minimum wage, will not qualify for Social Security disability benefits—even if the nearest parking garages or theaters that still use ushers are 150 miles away. Finally, if this extreme version of disability lasts less than 12 months, you are also out of luck.

Even if you are unfortunate enough to ultimately qualify medically, and even if you have paid enough into the system to qualify financially, you may have to wait years before you see one red cent. Approximately half of all people who apply for Social Security Disability at their local office will be turned down. They will then be forced to endure at least months, and sometimes years, of legal proceedings before getting a final answer. I have had cases that took two to four years before the disabled worker finally got his or her benefits. I am sure that some lost homes or vehicles because mortgages went unpaid.

> **"Any privatization of the Social Security retirement plan should also include some form of privatization for the Disability component as well."**

Private Sector a Better Fit

Compare this with most private disability plans, where the customer can purchase the plan that best suits his or her needs. For example, I obtained disability insurance (which I purchased soon after discovering how Social Security Disability works) that pays after 60 days of disability. Disability is defined according to my specific sub-occupation, e.g., the need to be physically (and mentally) able to try cases in court.

I could have made my coverage effective after just 30 days of disability, if I had wanted to pay more for the coverage, and I could have accepted a less restricted definition of disability, e.g., simply the ability to practice some type of law, if I had wanted to pay less. Many employer-provided disability plans will also define disability based upon the employee's specific job with that employer, at least for a limited period of time. Those plans will typically then require, after a period of years, that the employee satisfy criteria similar to, or the same as, Social Security's.

The key difference is that the employee need not be disabled for a year or more, and the definition of disability is reasonably and rationally related to the actual work or job the employee was doing. Thus, the employee has a reasonable amount of time to make a transition to some other type of work, if possible. Under the present Social Security disability system, the employee is forced to pay for what may be described as an "all-or-nothing" plan. If, after paying his Social Security taxes, he does not have enough to pay for a supplemental private disability plan, he is stuck on the federal plantation.

Despite my criticisms of the present system, I would be remiss if I didn't point out that most, if not all, private disability plans factor Social Security Disability into their programs. For example, most disability plans will offset the benefits they pay by whatever disability payments the insured may receive from Social Security. One company I was aware of simply based its decision entirely upon whatever Social Security decided.

Nevertheless, these plans were selected by the insureds (or their employers), and they knew what benefits they were supposed to get for their premium dollar. Under the present federal scheme, taxpayers have no say as to what type of disability coverage they have under Social Security . . . unless they can convince Congress and the President to modify the statutes and regulations. A "one-size-fits-all plan" is not exactly the wave of the future in this country.

Policing for Fraud

We cannot ignore, however, the fact that if Social Security Disability is replaced with private disability coverage there would still be a need to scrutinize claims. There will always be insureds trying to get something for nothing, and there will always be companies that will not pay out when they should. The huge infrastructure that Social Security Disability now has to process disputed claims cannot disappear without some increased burden on the local public sector.

However, each state already has to deal with disputes between private disability plans and their insureds. The only change would be in volume. Fortunately, local standards and practices could prevail, as opposed to the present nationwide practice that is inherent in a federal program.

Some states might prefer to keep any increases in case filings in their civil courts. Other states might prefer to place the burden on existing state or local administrative agencies, such as workers compensation, which already exist to make determinations for other benefits based upon full or partial disability. No matter how each state chose to deal with the problem, the net effect would be more local control over the process.

> **"Approximately half of all people who apply for Social Security Disability at their local office will be turned down. They will then be forced to endure at least months, and sometimes years, of legal proceedings before getting a final answer."**

Ultimately, changes need to be made. Any privatization of the Social Security retirement plan should also include some form of privatization for the Disability component as well.

Dewey L. Crepeau is a private practice attorney in Columbia, Missouri focusing on workers' compensation and Social Security Disability. He is the former assistant prosecuting attorney for Morgan County, Missouri and former assistant public defender for the state's 13th Judicial Circuit. He has been an adjunct professor in the Political Science Department at Columbia College and in the Department of Management at the University of Missouri-Columbia. Dewey, who joins Health Care News *as a contributing editor with this issue, can be reached by email at dcrepeau@socket.net*

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My Turn

Patients' Rights Debate Lacks Honesty

BY CONRAD F. MEIER

There is something very important missing from the Patients' Bill of Rights (PBOR) . . . and from the politicians' discussion of what the pending legislation entails.

In a word, *honesty* is missing. What we are not being told is that a very large segment of the population is in for a big shock: They are excluded from any protection under legislation currently being considered.

More than 80 Million Excluded

Over 45 million seniors insured by Medicare will not be able to file suit against the government for alleged denial of claims. Another 20 million Americans insured by Medicaid; 3.2 million VA beneficiaries; 7.3 million children covered by the Children's Health Insurance Program; and over 3 million government employees insured in the Federal Employee Health Benefits Plan would also be excluded from the Bill of Rights' mandates, directives, and litigation provisions.

Stephen Barchet MD, retired rear admiral in the United States Navy and project manager for the Defined Contribution Project at the Evergreen Foundation, reminded me I should add 8 million more American men and women, dependents, and retirees in the armed forces who are insured by the federal TRICARE program.

Can't Afford the Litigation

It is widely acknowledged the government health care system is shot full of so many administrative holes that fraud and abuse are no longer the exception. Democrats and Republicans know this . . . and they are unwilling to expose the country's largest health care provider to potential litigation.

According to Robert Moffit, director of public policy studies at The Heritage Foundation, "This is not an oversight. This is deliberate. The reason is that the government can't afford it. They know that there would be an absolute explosion in costs to defend lawsuits. In Medicare, for instance, the denial of claims for medical necessity exceeds that of the private sector."

Why are Democrats and some Republicans unwilling to expose federal health plans to litigation, yet very willing to expose the private sector to what they admit is a dangerous and expensive piece of health care reform? How they can turn face and say the negative effect on the private sector will be minor?

Why should private health insurers be subjected to a health care system the federal government rejects for its own beneficiaries?

> **"[A] very large segment of the population is in for a big shock: They are excluded from any protection under [patients' rights] legislation currently being considered."**

Given the reality of a country rapidly growing older, with more Americans going on federal health insurance plans excluded from the protection of the so-called patients' bill of rights, the smaller and younger population will be left to shoulder the increased costs.

Avoiding the Real Issues

This is no bill of rights for anyone, and it's no bargain for my growing family of grandchildren. At best, it is a diversion from having to deal with the more difficult problems of the increasing uninsured rate, expanding MSA legislation, passing health insurance tax reform law, and in the larger scope of things, restoring free-market order to the health care system. At worst, it's another incremental attempt to over-regulate our health care system to the point where a single-payer health plan will look like a good alternative.

The PBOR is now in the hands of the House of Representatives. We can only hope they will show themselves to be representatives of common sense, and admit most of what they are trying to accomplish is already being addressed at the state level and in the private sector.

That would allow our national politicians to save face, scrap the PBOR, go home early for Thanksgiving . . . and best of all, "do no harm."

Health Care Reform on the Web

COMPILED BY CONRAD F. MEIER

Ever wonder how the managing editor stays abreast of breaking developments in health care reform? In two words: the Internet.

The Web sites described here, listed in alphabetical order, represent a very small sampling of sites worth visiting on a regular basis if you're trying to monitor health care reform. This is by no means a complete list. In fact, if you have bookmarked a valuable Web site that doesn't appear in this list, please let me know! Send an email message to meier@heartland.org.

American Association of Physicians and Surgeons
The voice of market-oriented medical professionals. **http://www.aapsonline.org**
Medical Sentinel, an AAPS publication. **http://www.haciendapub.com**

American Legislative Exchange Council
The voice of state elected officials. Excellent site for studies and model legislation. **http://www.alec.org**

Business Journals
A great news source. Can be customized. **http://www.bizjournals.com**

CFMResearch
My personal Web site, offering regular health care reform updates. **http://cfmresearch.tripod.com/loosingourway/index.html**

Council for Affordable Health Insurance
Organization of health insurers with a powerful voice in D.C. Note: Membership fee required to access "insider" information on the Web site. **http://www.cahi.org**

Families USA
Spinning to the left. This one site will keep you in touch with the liberal agenda. **http://www.familiesusa.org**

The Galen Institute
Organizers of the Consensus Group. Another really good source for research and weekly email updates. **http://www.galen.org**

Health Insurance Association of America
These folks are on top of breaking news and issues. **http://www.hiaa.org**

The Heartland Institute
Outstanding and award-winning free-market Web site offering a wealth of policy information not only on health care reform, but on dozens of other topics as well. Heartland's PolicyBot database and search engine put over 7,500 documents in Adobe's popular PDF format at your fingertips—free. **http://www.heartland.org**

The Heritage Foundation
A major player in the Washington, DC health care debate. **http://www.heritage.org**

Institute for Policy Innovation
Extensive library of policy studies, issue briefs, newsletters, and books. **http://www.ipi.org**

National Association of Health Underwriters
Home for professional health insurance agents and brokers. Good source for information about state and federal legislative activities. **http://www.nahu.org**

National Center for Policy Analysis
A must read, early and often. Sign up for email updates from NCPA and from *Health Care News* Assistant Editor Greg Scandlen. **http://www.ncpa.org**

National Center for Public Policy Research
Dozens of reports on health care and retirement security. **http://www.nationalcenter.org**

The RAND Group
Premier research and analysis on all manner of social issues. **http://www.rand.org**

Stateline
Leaning to the left of center, but an excellent news source. **http://www.stateline.org**

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Linda Chavez:

"Still Fighting for the American Dream"

Linda Chavez is president of the Center for Equal Opportunity, a non-profit public policy research organization in Washington, DC. She also writes a weekly syndicated column that appears in newspapers across the country (including the *Chicago Sun-Times*), and is a political analyst for FOX News Channel.

Chavez is the author of *Out of the Barrio: Toward a New Politics of Hispanic Assimilation* (Basic Books, 1991), which the *Denver Post* said "should explode the stereotypes about Hispanics that have clouded the minds of patronizing liberals and xenophobic conservatives alike." *The Washington Post* describes Chavez as one of "a new generation of intellectuals [seeking] to question the orthodoxies of the civil rights establishment." Chavez is well known for her syndicated newspaper column and writings for other publications, including the *Wall Street Journal*, *The New Republic*, the *Washington Post*, and *Reader's Digest*.

Mark Skousen:

"The Vindication of Adam Smith"

Mark Skousen is an investment advisor, author, and dynamic world-renowned speaker. A self-described "almost idealistic" proponent of liberty and political freedom with a Ph.D. in economics, Skousen is actively involved in some of the most prestigious free-market and liberty think tanks in the world.

Skousen is the author of many books, including *The Making of Modern Economics* (M.E. Sharpe Publishers, 2001), *Economic Logic* (Skousen Publishing, Inc., 2000), *Economics of a Pure Gold Standard* (Foundation for Economic Education, 1997), and *Complete Guide to Financial Privacy* (Simon & Schuster, 1983).

Skousen has built a reputation for accurately identifying not only economic and political trends, but also the right investments for the times. *Mark Skousen's Forecasts & Strategies* has grown to become one of the largest financial newsletters in the country.

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